Region 17 Regional Healthcare Partnership

Provider Meeting

Wednesday, September 19, 2012 • 9:00 a.m. to 10:30 a.m.

Texas A&M Health Science Center • Clinical Building 1 • Executive Conference Room, Suite 3100 (3rd Floor)
8441 Highway 47 • Bryan, Texas 77807

AGENDA

I. Welcome and Introductions

II. Updates from HHSC Anchor Call

a. Timelines
b. UC Tool
c. Planning Protocol
d. RHP Template
e. Remaining Q&A

III. Review Key Points of Final PFM Protocol

a. Pass 1/Pass 2 Requirements
b. Small and Rural Hospital Exemption

IV. Review and Discuss RHP Planning Protocol

a. Categories 1 and 2
b. Category 3
c. Measures/Metrics
d. Category 4

V. Review Final RHP Plan Template

VI. Next Steps

a. Remaining RHP 17 Timeline & Tasks
b. Project Development Assistance
c. Q&A for HHSC

VII. Adjourn

08/31/12

Summary of Texas DSRIP Project Requirements

	Categories 1 & 2	Category 3	Category 4
Performing Provider	Hospital and non-Hospital Providers	Hospital and non-Hospital Providers	Hospital Providers* only
Pass 1 Projects & Requirements			
	RHP Level Requirement	Performing Provider Level Requirement	
Project Begins	DY 2	DY 2 and DY 3	DY 3 and DY 4
RHP Tier 1	Minimum 20 projects (At least 10 from Category 2)	Must adopt outcome measures that tie back to projects in Categories 1 and 2. Must establish outcome improvement targets by DY 4.	5 Domains of Measures: • PPA's • PPR's • PPC's • Patient Centered Health Care • Emergency Department DY 2 DSRIP for status report on system changes.
RHP Tier 2	Minimum 12 projects (At least 6 from Category 2)		
RHP Tier 3	Minimum 8 projects (At least 4 from Category 2)		
RHP Tier 4	Minimum 4 projects (At least 2 from Category 2)		
Broad Participation Target/ Pass 2	• RHPs shall have minimum participation by non-profit and other private hospitals (Tier 1 & 2: 30%; Tier 3: 15%, Tier 4: 5%). • RHPs shall have minimum participation by major safety net hospitals (Tier 1: five; Tier 2: four; Tier 3: two; Tier 4: one) • An RHP that meets minimum provider participation requirements in Pass 1 may participate in Pass 2 and fund additional projects with unused DSRIP allocation amounts.		
Plan Modification			**DSRIP Requirements for UC Pool Participants**
All RHPs	• An RHP may add new projects/outcome measures to begin in DY 3 from Categories 1, 2, or 3. • Proposals must be submitted during DY 2. • RHP may also delete or modify projects, under certain circumstances. • Plan modifications are subject to HHSC and CMS review and approval.		• Hospitals that participate in UC pool shall be required to report on a subset of Category 4 measures. • Fourth quarter UC payments are contingent on Category 4 reporting. • Participation in an annual learning collaborative. • Certain exceptions apply.

*Certain small hospitals and rural hospitals are exempt from reporting Category 4 measures (see paragraph 11.f of Attachment J: Program Funding and Mechanics Protocol).

08/31/12

Highlights of Texas DSRIP Funding Methodology

DSRIP Allocation to RHPs

- Initial DSRIP amounts allocated to RHPs in DYs 1-5 based on a formula that consider three factors (low-income population, Medicaid spending, and supplemental payments).
- HHSC shall re-assess RHP allocation amounts in DY 2: uncommitted amounts shall be redistributed to RHPs that implement new projects in DYs 3-5, subject to plan modification approval.

RHP DSRIP Allocation to Performing Providers (DYs 2-5)

Pass 1

- 75% to Hospital Providers that participated in DSH program in FFY 2012 or UPL program in FFY 2011 (formula distributes a specific amount to each hospital based on uncompensated care, Medicaid spending, and supplemental payments);
- 10% to Community Mental Health Centers; 10% to Physician Practices Affiliated with Academic Health Science Centers; and 5% to Local Health Departments.
- Small hospital collaboration: Within an RHP categorized as Tier 1 or 2, hospitals with a DY 2 allocation of $2 million or less may combine their individual DSRIP allocations together to fund a project(s) led by one Performing Provider.
- Tier 3 and Tier 4 collaboration: Within an RHP categorized as Tier 3 or 4, Performing Providers may combine their individual DSRIP allocations together to fund a project(s) led by one Performing Provider.

Pass 2

- Uncommitted DSRIP in Pass 1 may be used to fund additional projects from Categories 1-3.
- 15% to hospitals that did not participate in the DSH program or former UPL program.
- 10% to physician practices unaffiliated with Academic Health Science Centers.
- 75% to Performing Providers that participated in Pass 1 based on the value of DSRIP projects funded in Pass 1 in DYs 2-5.
- Within an RHP, Performing Providers may combine their individual Pass 2 DSRIP allocations to fund a DSRIP project led by 1 Performing Provider.

Rules of the Road

To get to Pass 2, RHP must meet (1) minimum number of Category 1 and 2 projects; (2) show minimum participation by major safety net hospitals; and (3) demonstrate minimum participation by non-profit/private hospitals.

Performing Provider Project Valuations (DYs 2-5)

Performing providers shall allocate their DSRIP funding to projects in a manner that comports with the category funding allocation requirements below. Cat 1 and 2 project values may not exceed the greater of 10 percent of the Performing Provider's Pass 1 allocation or $20 million over the DYs 2-5 period

	DY 2 (10/1/12- 9/30/13)	DY 3 (10/1/13-9/30/14)	DY 4 (10/1/14-9/30/15)	DY 5 (10/1/15-9/30/16)
Hospitals*				
Categories 1 & 2	No more than 85 %	No more than 80%	No more than 75 %	No more than 57 %
Category 3	At least 10 %	At least 10%	At least 15 %	At least 33 %
Category 4	5 %	10 % - 15%	10 %- 15 %	10 % - 15 %
Non Hospitals:				
Categories 1 & 2	95 %-100 %	No more than 90 %	No more than 90 %	No more than 80 %
Category 3	0 %– 5 %	At least 10 %	At least 10 %	At least 20 %

* Small hospitals and rural hospitals exempted from Category 4 reporting shall allocate Category 4 funding to Categories 1-3.

State of Texas

DSRIP Allocation Model

Minimum Private DSRIP Funding by RHP to be eligible for Pass 2

RHP Tier for Private Funding	Minimum Private Funding %
1	30%
2	30%
3	15%
4	5%

			DY 2		DY3		DY4		DY5		GRAND TOTAL (DY 2-5)	
RHP	RHP Tier Level	Minimum Private Funding %	Private Hospital DSRIP	DY2 Private Minimum Funding Requirement	Private Hospital DSRIP	DY3 Private Minimum Funding Requirement	Private Hospital DSRIP	DY4 Private Minimum Funding Requirement	Private Hospital DSRIP	DY5 Private Minimum Funding Requirement	Private Hospital DSRIP	TOTAL Private Minimum Funding Requirement
1	3	15%	$52,766,546	$7,914,982	$61,163,309	$9,174,496	$65,430,517	$9,814,578	$71,120,127	$10,668,019	$250,480,499	$37,572,075
2	3	15%	$37,587,589	$5,638,138	$43,568,918	$6,535,338	$46,608,610	$6,991,292	$50,661,533	$7,599,230	$178,426,650	$26,763,998
3	1	30%	$193,095,526	$57,928,658	$223,822,901	$67,146,870	$239,438,452	$71,831,536	$260,259,187	$78,077,756	$916,616,066	$274,984,820
4	3	15%	$35,140,395	$5,271,059	$40,732,302	$6,109,845	$43,574,090	$6,536,114	$47,363,141	$7,104,471	$166,809,928	$25,021,489
5	4	5%	$117,382,464	$5,869,123	$136,061,586	$6,803,079	$145,554,255	$7,277,713	$158,211,147	$7,910,557	$557,209,451	$27,860,473
6	2	30%	$104,302,032	$31,290,610	$120,899,660	$36,269,898	$129,334,520	$38,800,356	$140,581,000	$42,174,300	$495,117,212	$148,535,164
7	3	15%	$64,919,293	$9,737,894	$75,249,928	$11,287,489	$80,499,923	$12,074,988	$87,499,916	$13,124,987	$308,169,060	$46,225,359
8	4	5%	$28,303,798	$1,415,190	$32,807,793	$1,640,390	$35,096,709	$1,754,835	$38,148,597	$1,907,430	$134,356,897	$6,717,845
9	2	30%	$142,457,521	$42,737,256	$165,126,849	$49,538,055	$176,647,327	$52,994,198	$192,007,964	$57,602,389	$676,239,660	$202,871,898
10	2	30%	$96,193,414	$28,858,024	$111,500,714	$33,450,214	$119,279,833	$35,783,950	$129,651,993	$38,895,598	$456,625,954	$136,987,786
11	4	5%	$15,735,033	$786,752	$18,238,956	$911,948	$19,511,441	$975,572	$21,208,088	$1,060,404	$74,693,518	$3,734,676
12	3	15%	$38,834,642	$5,825,196	$45,014,416	$6,752,162	$48,154,957	$7,223,243	$52,342,344	$7,851,352	$184,346,359	$27,651,954
13	4	5%	$9,812,949	$490,647	$11,374,488	$568,724	$12,168,057	$608,403	$13,226,148	$661,307	$46,581,641	$2,329,082
14	4	5%	$12,872,282	$643,614	$14,920,653	$746,033	$15,961,629	$798,081	$17,349,597	$867,480	$61,104,161	$3,055,208
15	3	15%	$30,305,061	$4,545,759	$35,127,519	$5,269,128	$37,578,276	$5,636,741	$40,845,952	$6,126,893	$143,856,807	$21,578,521
16	4	5%	$21,521,165	$1,076,058	$24,945,838	$1,247,292	$26,686,245	$1,334,312	$29,006,788	$1,450,339	$102,160,035	$5,108,002
17	4	5%	$32,686,956	$1,634,348	$37,888,446	$1,894,422	$40,531,826	$2,026,591	$44,056,332	$2,202,817	$155,163,560	$7,758,178
18	4	5%	$21,028,469	$1,051,423	$24,374,738	$1,218,737	$26,075,301	$1,303,765	$28,342,719	$1,417,136	$99,821,227	$4,991,061
19	4	5%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
20	4	5%	$24,870,212	$1,243,511	$28,827,820	$1,441,391	$30,839,063	$1,541,953	$33,520,721	$1,676,036	$118,057,815	$5,902,891
Total			**$1,079,815,347**	**$213,958,243**	**$1,251,646,832**	**$248,005,512**	**$1,338,971,030**	**$265,308,222**	**$1,455,403,293**	**$288,378,502**	**$5,125,836,502**	**$1,015,650,479**

CATEGORY 1

1.1 Expand Primary Care Capacity

1.1.1 Establish more primary care clinics

1.1.2 Expand existing primary care capacity

Required core project components:

a) Expand primary care clinic space

b) Expand primary care clinic hours

c) Expand primary care clinic staffing

1.1.3 Expand mobile clinics

1.1.4 Implement other evidence based project to enhance primary care capacity in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must use relevant process metrics and report on the improvement metrics listed under milestone I-X.

1.2 Increase Training of Primary Care Workforce

1.2.1 Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement

1.2.2 Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/*promotoras*).

1.2.3 Increase the number of residency/training program for faculty/staff to support an expanded, more updated program

1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas (HPSAs)

1.3 Implement a Chronic Disease Management Registry

1.3.1 Implement/enhance and use chronic disease management registry functionalities

Required core project components:

a) Enter patient data into unique chronic disease registry

b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

c) Use registry reports to develop and implement targeted QI plan

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.

1.3.2 Introduce other evidence based projects to implement and use registry data in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

1.4 Enhance Interpretation Services and Culturally Competent Care

1.4.1 Expand access to written and oral interpretation services

a) Identify and address language access needs and/or gaps in language access

b) Implement language access policies and procedures (in coordination with statewide and federal policies to ensure consistency across the state)

c) Increase training to patients and providers at all levels of the organization related to language access and/or cultural competency/sensitivity

d) Increase interpretation staff

1.4.2 Enhance Organizational Cultural Competence.

a) Hire, promote, and retain minorities at all levels of the organization to increase diversity in the health care workforce.

b) Develop a program that actively involves community representatives in the health care organization's planning and quality improvement meetings, whether as part of the board or as part of focus groups.

1.4.3 Enhance Systemic Cultural Competence

a) Develop policies and procedures to measure systemic culture competence, or use existing evidence-based culturally competency assessment tool (e.g., CAHPS Cultural Competency Supplement).

b) Adopt and implement all 14 CLAS standards, including those that are not federal mandates.[1]Conduct CLAS Standards trainings at facilities

c) Identify federal and state reimbursement strategies for interpreter services and identify community resources and partnerships to develop the needed workforce.

d) Provide staff training around Title VI requirements mandating the provision of interpreter services in health care settings.

e) Identify and use tools to detect medical errors that result from lack of systemic cultural competence, including those stemming from language barriers (e.g., taking a prescribed medication incorrectly); misunderstanding health education materials, instructions, or signage (e.g., inappropriately preparing for a diagnostic or therapeutic procedure, resulting in postponement or delay); and misunderstanding the benefits and risks of procedures requiring informed consent.

f) Implement projects to address medical errors resulting from systemic cultural competency.

1.4.4 Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels. The curricula should:

a) increase awareness of racial and ethnic disparities in health and the importance of socio-cultural factors on health beliefs and behaviors;

b) address the impact of race, ethnicity, culture, and class on clinical decision making;

c) develop tools to assess the community members' health beliefs and behaviors

d) Develop human resource skills for cross-cultural assessment, communication, and negotiation.

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[1] http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

1.4.5 Implement Quality improvement efforts that include culturally and linguistically appropriate patient survey methods as well as process and outcome measures that reflect the needs of multicultural and minority populations.

1.4.6 Clinical Cultural Competence: Develop programs to help patients navigate the health care system and become a more active partner in the clinical encounter.

1.4.7 Implement other evidence based project to enhance language services and culturally competent care in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

1.5 Collect Valid and Reliable Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

1.5.1 Train patients and staff on the importance of collecting REAL data (For project option 1.5.1, the provider must do both subpart (i) and subpart (ii), If the provider is not using existing curriculum. If the provider is using existing curriculum, only subpart (ii) is required.):

i. Develop curriculum that includes effective strategies to explain relevance of collecting REAL data to patients and staff. Education about the value of the information for patient care, with clear examples of the benefits of data collection is central to an effective training.

ii. Train patients and staff on the importance of collecting REAL data using developed or existing curricula.

1.5.2 Implement intervention that involves collaborating/partnering/ instituting data sharing agreements with Medicaid agencies, public health departments, academic research centers, other agencies, etc. to better assess patient populations and aid in the evaluation of health disparities

1.5.3 Implement project to enhance collection, interpretation, and / or use of REAL data. Providers may select one or more of the following project components, as appropriate for the provider's starting point in collection and use of REAL data: Required core project components:

a) Redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care

b) Implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.

c) Develop improvement plans, which include a continuous quality improvement plan, to address key root causes of disparities within the selected population.

d) Use data to undertake interventions aimed at reducing health and health care disparities (tackling "the gap") for target patient populations through improvements in areas such as f preventive care, patient experience, and/or health outcomes.

1.5.4 Introduce other evidence-based projects to implement and use REAL data in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

1.6 **Expand Access to Urgent Care and Enhance Urgent Medical Advice**

1.6.1 Expand urgent care services

1.6.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.

Required core project components:

a) Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.

b) Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.

c) 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.

1.6.3 Introduce other evidence based projects to implement and utilize urgent medical advice in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

1.7 **Introduce, Expand, or Enhance Telemedicine/Telehealth**

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

Required core project components:

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.

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

1.7.3 Use telehealth to deliver specialty, psychosocial, and community-based nursing services

1.7.4 Develop a tele-dentistry infrastructure and use telehealth to provide dental and oral health services.

1.7.5 Use telehealth services to provide medical education and specialized training for targeted professionals in remote locations.

1.7.6 Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and

guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

1.7.7 Implement other evidence based project to expand/establish telemedicine/telehealth program to help fill significant gaps in services in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on, at minimum, all of the improvement metrics listed under improvement milestone

1.8 Increase, Expand, and Enhance Oral Health Services

Increase dental provider training, education, recruitment and/or retention, as well as expand workforce capacity through one of the following project options:

1.8.1 The 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.

1.8.2 The establishment of a clinical rotation, continuing education within various community settings for dental residents to increase their exposure and experience providing dental services to special populations such as the elderly, pregnant women, young children, medically compromised, and/or special needs patients.

1.8.3 The establishment of a loan repayment program or scholarships for advanced training/education in a dental specialty with written commitments to practice in underserved markets after graduation for fourth year dental students, new dental and dental hygiene graduates, and dental residents.

Increase interdisciplinary training and education opportunities for dentists and other health care providers to promote an interdisciplinary team approach to addressing oral health through one of the following project options:

1.8.4 Grand rounds, in-service trainings, and other continuing education events that integrate information on oral health issues and implications as related to chronic diseases, such as diabetes and cardiovascular disease, and the importance of good oral health during pregnancy and perinatal period.

1.8.5 Establishing a referral system/network that provides medically complex patients with coordinated care between dental and medical providers such as cardiologists, pediatricians, OB/GYNs, endocrinologists, oncologists, etc.

Increase and expand services by increasing clinics, clinic hours, using satellite mobile clinics with an affiliated fixed-site dental clinic location, school-based/school-linked health centers or other approaches to increase oral health services to underserved populations through one of the following project options:

1.8.6 The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.

1.8.7 The expansion or establishment of satellite mobile dental clinics with an affiliated fixed-site dental clinic location.

1.8.8 The development of tele-dentistry infrastructure including Medicaid reimbursement to expand access to dental specialty consultation services in rural and other limited access areas.

1.8.9 The implementation or expansion of school-based sealant programs that provide sealants 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.

1.8.10 The addition or establishment of school-based health centers that provide dental services for otherwise unserved children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LDHs, FQHCs, and/or local dental providers.

1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers.

1.8.12 Project Option for a customized outcome in a Category 3 domain J: **Improvements in Oral Health:** Implement an innovative and evidence based intervention that will lead to improvements in Oral Health services delivery for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain J, "Improvements in Oral Health"**[4]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed in the milestones section of this project area to describe how the proposed milestones relate to the specific intervention goals.

Note: The following project components to implement or enhance efforts to improve quality of care and quality assurance in the delivery of dental care may be included as a part of the above project options:

- Integrating oral health information with electronic medical record.
- Establishing dental care coordination collaboratives where dental case studies are reviewed by dental and medical healthcare providers in an effort to identify best practices and to evaluate health outcomes as a result of the dental interventions and services provided.

1.9 Expand Specialty Care Capacity

1.9.1 Expand high impact specialty care capacity in most impacted medical specialties
Required core project components:

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

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

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

d) 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.

1.9.2 Improve access to specialty care

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system
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.

1.9.3 Implement other evidence based project to enhance specialty care capacity in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under improvement milestone I-X.

1.10 **Enhance Performance Improvement and Reporting Capacity**

1.10.1 Enhance improvement capacity within people

Required core 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.

1.10.2 Enhance improvement capacity through technology

Required core 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 (possible examples include weekly run charts or monthly dashboards)

1.10.3 Enhance improvement capacity within systems

Required core 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.

1.10.4 Implement other evidence based project to enhance performance improvement and reporting capacity in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on improvement metrics listed under Milestone I-10.

1.11 **Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services**

1.11.1 Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state (this must be combined with one of the two interventions below).

Required core project components:

a) Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state;

b) Assess the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.

c) Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.

1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers).

Required core project components:

a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.

b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.

c) Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer.

d) Identify modifiers needed to track encounters performed via telehealth technology

e) Develop and implement data collection and reporting standards for electronically delivered services

f) Review the intervention(s) impact on access to specialty 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.

g) Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations.

h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions)

1.11.3 In an innovative manner not described above, implement other evidence-based, technology-assisted services to support, coordinate, or deliver behavioral health services. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

1.12 **Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care**

1.12.1 Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based settings in areas of the State where access to care is likely to be limited.

Required core project component:

a) Evaluate existing transportation programs and ensure that transportation to and from medical appointments is made available outside of normal operating hours. If transportation is a significant issue in care access, develop and implement improvements as part of larger project.

b) Review the intervention(s) impact on access to behavioral health services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

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

1.12.3 Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished areas of Texas.

1.12.4 In an innovative manner not described above, implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

1.13 **Development of behavioral health crisis stabilization services as alternatives to hospitalization.**

1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system

Required core project components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

1.13.2 In an innovative manner not described above, implement other evidence-based project to develop behavioral health crisis stabilization services as alternatives to hospitalization. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

1.14 **Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas (e.g., psychiatrists, psychologists, LMSWs, LPCs and LMFTs.)**

1.14.1 Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county. Examples of strategies could include marketing campaigns to attract providers, enhanced residency programs or structured financial and non-financial incentive programs to attract and retain providers, identifying and engaging individual health care workers early in their studies/careers and providing training in identification and management of behavioral health conditions to other non-behavioral health disciplines (e.g., ANPs, PAs).

Core project components:

a) Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps.

b) Develop plan to remediate gaps identified and data reporting mechanism to assess progress toward goal. This plan will specifically identify:

- The severity of shortages of behavioral health specialists in a region by type (psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, peer support specialists, community health workers etc.)
- Recruitment targets by specialty over a specified time period.
- Strategies for recruiting healthcare specialists

- Strategies for developing training for primary care providers to enhance their understanding of and competency in the delivery of behavioral health services and thereby expand their scope of practice.

c) Assess and refine strategies implemented using quantitative and qualitative data. Review the intervention(s) impact on behavioral health workforce in HPSA areas and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

1.14.2 In an innovative manner not described above, implement other evidence-based workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

CATEGORY 2

2.1 **Enhance/Expand Medical Homes**

2.1.1 Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Required core project components:

a) Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.

b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status

c) Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.

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.

2.1.2 Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.

Required core project 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.

2.1.3 Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative:

Required core project components:

a) Empanelment: Assign all patients to a primary care provider within the medical home. Understand practice supply and demand, and balance patient load accordingly.

b) Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.

d) Assure that patients are able to see their provider or care team whenever possible.

e) Promote and expand access to the medical home by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.

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.

2.1.4 Implement other evidence based project to develop or enhance Patient-Centered Medical Home Models in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-19.

2.2 **Expand Chronic Care Management Models**

2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Required core project components:

a) Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system

b) Ensure that patients can access their care teams in person or by phone or email

c) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs

2.2.3 Redesign rehabilitation delivery models for persons with disabilities

2.2.4 Develop a continuum of care in the community for persons with serious and persistent mental illness and co-occurring disorders

2.2.5 Develop care management functions that integrate the primary and behavioral health needs of individuals

2.2.6 Implement other evidence based projects to expand chronic care management in an innovative manner not described above. Note, providers opting to implement other innovative projects under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-22.

2.3 **Redesign Primary Care**

2.3.1 Redesign primary care in order to achieve improvements in efficiency, access, continuity of care, and patient experience

Required core project components:

a) Implement the patient-centered scheduling model in primary care clinics

b) Implement patient visit redesign

c) 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.

2.3.2 Implement other evidence based project to redesign primary care capacity in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

2.4 **Redesign to Improve Patient Experience**

2.4.1 Implement processes to measure and improve patient experience

Required core project components:

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.

2.4.2 Implement other evidence based project to improve patient experience in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

2.4.3 Project Option: Increased patient satisfaction

Implement an innovative and evidence based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category ,3 Domain F, "Increased Patient Satisfaction"**. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.5 Redesign for Cost Containment

2.5.1 Develop an integrated care model with outcome-based payments

Required core project components:

a) Implement cost-accounting systems to measure intervention impacts
b) Establish a method to measure cost containment
c) Establish a baseline for cost
d) Measure cost containment

2.5.2 Implement other evidence based project to redesign for cost containment in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-11.

2.5.3 Project Option: Cost Savings

Implement an innovative and evidence based intervention that will lead to **cost savings** for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3 Domain E, "Cost Savings"**[2]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.6 Implement Evidence-based Health Promotion Programs

2.6.1 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population.

2.6.2 Establish self-management programs and wellness using evidence-based designs.

2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

2.6.4 Implement other evidence based project to implement health promotion programs in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-8.

Note: All of the project options in 2.6 should include a component to 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,"

2 Category 3 Outcome Measures document

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.

2.7 Implement Evidence-based Disease Prevention Programs

- 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)
- 2.7.2 Implement innovative evidence-based strategies to reduce tobacco use.
- 2.7.3 Implement innovative evidence-based strategies to increase early enrollment in prenatal care.
- 2.7.4 Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.
- 2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
- 2.7.6 Implement other evidence-based project to implement disease prevention programs in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on improvement metrics listed under milestone I-7.

Note: All of the project options in 2.7 should include a component to 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.

2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency

- 2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
  - a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
  - 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) 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).
  - d) Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.
  - e) Implement software to integrate workflows and provide real-time performance feedback.
  - f) Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.
- 2.8.2 Implement other evidence based project to apply process improvement methodology in an innovative manner not described above. Note, providers opting

to implement an innovative project under this option must propose relevant process metrics and report on improvement metrics listed under milestone I-7

Project Options tied to a customized outcome in a specified Category 3 domain

2.8.3 Project Option: Reduction in Potentially Preventable Admission Rates (PPAs)
Implement an innovative and evidence based intervention that will lead to **reductions** in Potentially Preventable Admissions (PPAs) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain A, "Potentially Preventable Admissions"**[3]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y, and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.4 Project Option: Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)4
Implement an innovative and evidence based intervention that will lead to reductions in 30 Day Readmissions for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3 Domain B, "30-Day Hospital Readmissions" (Potentially Preventable Readmissions)**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y, and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.5 Project Option: Reduction in Potentially Preventable Complications (PPC)
Implement an innovative and evidence based intervention that will lead to **reductions** in Potentially Preventable Complications (PPCs) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain C, "Potentially Preventable Complications"**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.6 Project Option: Reduce Inappropriate ED Use
Implement an innovative and evidence based intervention that will lead to **reductions** in inappropriate Emergency Department use for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain D, "Reduce Inappropriate ED Use"**[1]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

3 Category 3 Outcome Measures document
4 http://www.hhsc.state.tx.us/reports/2012/potentially-preventable-readmissions.pdf

2.8.7 Project Option: Improved Clinical Outcome for Identified Disparity Group
Implement an innovative and evidence based intervention that will lead to **improvements** in clinical outcomes for an identified disparity group for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain G, "Improved Clinical Outcome for Disparity Group"**[5]. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.8 Project Option: Improved Access to Care
Implement an innovative and evidence based intervention that will lead to **increase** in access to care for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain H, "Improved Access to Care"**[3]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.9 Project Option: Improvement in Perinatal Health Indicator(s)
Implement an innovative and evidence based intervention that will lead to **improvements** in perinatal health outcomes for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain I, "Improvement in Perinatal Health Indicator(s)"**[3]. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.10 Project Option: Improve Clinical Indicator for Target Population
Implement an innovative and evidence based intervention that will lead to **improvements** in a selected clinical indicator for a targeted population for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain K, "Improve Clinical Indicatory for Target Population"**[3]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.11 Project Option: Sepsis
Implement an innovative and evidence based intervention that will lead to **reductions** in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain L, "Sepsis"**[6]. Providers selecting this project option should use process milestone(s) X, improvement milestone(s) Y and the

5 Category 3 Outcome Measures document
6 Category 3 Outcome Measures document

milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.8.12 Project Option: Other

Implement an innovative and evidence based intervention that will lead to improvements in a health outcome not include elsewhere for providers that have demonstrated need or unsatisfactory performance in this area. This project requires reporting of specific metric(s) as associated with corresponding outcome(s) listed in **Category 3, Domain M, "Other"**. Providers selecting this project option should use process milestones X, improvement milestones Y and the milestone development template listed at the conclusion of this project area to describe how the proposed milestones relate to the specific intervention goals.

2.9 Establish/Expand a Patient Care Navigation Program

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.

2.9.2 Implement other evidence based projects to expand patient navigation services in an innovative manner not described above. Note, providers opting to implement other innovative projects under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-10.

2.10 Use of Palliative Care Programs

2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

Required core project components:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
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. 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.

2.10.2 Implement other evidence based project to expand/establish a palliative care program in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on, at minimum, all of the improvement metrics listed under improvement milestone I-6.

2.11 **Conduct Medication Management**

2.11.1 Implement interventions that put in place the teams, technology, and processes to avoid medication errors

Required core project 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. 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.

2.11.2 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) Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations

b) Implement *Computerized Physician Order Entry* (CPOE)

c) Implement pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers.

2.11.3 Implement other evidence based project to develop or enhance Medication Management in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under measure.

2.12 **Implement/Expand Care Transitions Programs**

2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions

Required core project components:

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.

2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:

- Discharge checklists
- "Hand off" communication plans with receiving providers
- Wellness initiatives targeting high-risk patients
- Patient and family education initiatives including patient self-management skills and "teach-back"
- Post-discharge medication planning
- Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.

2.12.3 Implement other evidence-based project to enhance care transitions in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-X.

Note: Providers selecting one of these project options should ensure that overlaps do not exist with the EHR Incentive Program or other available demonstration funding.

2.13 **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.).**

2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Required core components:

a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
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 and 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.

2.13.2 In an innovative manner not described above, implement other evidence-based project for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

Note: Community-based interventions should be comprehensive and multispecialty. They should incorporate two or more components, such as those listed below depending on the needs of the target populations being served. These interventions should have significant flexibility to add more components if they are appropriate to meet the needs of the target population. Community-based components may include (but are not limited to):

- Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services)
- Assisted living;
- Cognitive Adaptation Training (CAT) – an evidence-based service that uses tools and motivational techniques to establish and refine daily living skills;
- Psychosocial Rehabilitation;
- Supported employment;
- Minor home modifications;

- Home delivered meals;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Adaptive aids (e.g., medication-adherence equipment, communication equipment, etc.);
- Transportation to appointments and community-based activities;
- Specialized behavioral therapies:
    - Cognitive Behavioral Therapy – An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking; and
    - Dialectical Behavior Therapy – A manualized treatment program (derived from cognitive behavioral therapy) that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings;
- Prescription medications;
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals;
- Respite care (short term);
- Substance abuse services (specialized for individuals who have experienced prolonged or repeated institutionalization);
- Visiting Nursing and / or community health worker services;
- Employment supports
- Nutritional counseling
- Occupational therapy; Speech and language therapy; and Physical therapy.

Components must be articulated into a system which uses a CQI design such as the CMS Quality Framework for HCBS services. (Anita Yuskauskas, 2010) and/or be informed by guidance such as the SAMHSA evidence-based toolkit for permanent supported housing (http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510) or other evidence-based system

2.14 **Implement person-centered wellness self-management strategies and self directed financing models that empower consumers to take charge of their own health care.**

2.14.1 Establish interventions to promote person-centered wellness self-management strategies and train staff / contractors to empower consumers to take charge of their own health care.

Required core project components:

a) Develop screening process for project inclusion
b) Identify population for intervention using claims and encounter data, clinical records, or referrals from providers.
c) Recruit eligible individuals based on administrative and diagnostic data
d) Establish interventions and train staff / contractors
e) Hire staff (including the following minimum qualifications):

- Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- WRAP Facilitator: an individual trained and credentialed as a WRAP facilitator using the WARP model developed by Mary Ellen Copeland (See: http://www.mentalhealthrecovery.com/wrap/).

f) Train staff in motivational interviewing and person-centered planning

g) Assess project outcomes. 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.

2.14.2 Implement self-directing financing models including wellness accounts. Note: If selected, this must be implemented as part of a person-centered wellness project as described in 2.14.1.

Required core project components:

a) Establish wellness account funding mechanisms.

b) Establish policies and procedures for program operations.

c) Establish accountability systems to track outcomes and expenditures.

d) Implement interventions.

e) Assess project outcomes.

2.14.3 In an innovative manner not described above, implement other evidence-based project in person-centered wellness self-management strategies and self directed financing models that empower consumers to take charge of their own health care. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

2.15 **Integrate Primary and Behavioral Health Care Services**

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. 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 Medical 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.

2.15.2 In an innovative manner not described above, implement other evidence-based project to integrate primary and behavioral health care services. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

2.16 **Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally.**

2.16.1 Design, implement, and evaluate a program to provide remote psychiatric consultative services to all participating primary care providers delivering services to patients with mental illness or substance abuse disorders

Required core project components:

a) Establish the infrastructure and clinical expertise to provide remote psychiatric consultative services.

b) Determine the location of primary care settings with a high number of individuals with behavioral health disorders (mental health and substance abuse) presenting for services, and where ready access to behavioral health expertise is lacking. Identify what expertise primary care providers lack and what they identify as their greatest needs for psychiatric and/or substance abuse treatment consultation via survey or other means.

c) Assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models

d) Build the infrastructure needed to connect providers to virtual behavioral health consultation. This may include:
   - Procuring behavioral health professional expertise (e.g., Psychiatrists, Psychologists, Psychiatric Nurses, Licensed Professional Counselors, Masters level Social Workers, Licensed Chemical Dependency Counselors, Licensed Marriage and Family Therapists, Certified Peer specialists, and Psychiatric Pharmacists,). This will include expertise in children and adolescents (e.g. Child and Adolescent Psychiatrists, Psychologists, Nurses, and Pharmacists); expertise in psychotropic medication management in severe mental illness.

e) Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24-hour basis.

f) Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation.

g) Provide outreach to medical disciplines in primary care settings that are in need of telephonic behavioral health expertise and communicate a clear protocol on how to access these services.

h) Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation.

i) Develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services.

j) Review the intervention(s) impact on access to telephonic psychiatric consults 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

Optional Project Components:

k) Develop a database or information resource center for behavioral health professionals to ensure appropriate research based interventions are being communicated to providers.

l) Develop or adapt best practice resources and research based literature to medical professions on a range of behavioral health topics that frequently occur in primary care settings (including guidelines for best practices for administration of psychotropic medications for specific mental health conditions and monitoring of these medications).

2.16.2 In an innovative manner not described above, implement other evidence-based project to provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

2.17 **Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.**

2.17.1 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders.

Required core project components:

a) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports

b) Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient and provider interviews.

c) Identify baseline mental health and substance abuse conditions at high risk for readmissions, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).

d) Review best practices for improving care transitions from a range of evidence-based or evidence-informed models

e) Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.

f) Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:

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.

2.17.2 In an innovative manner not described above, implement other evidence-based improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

Examples of interventions include, but are not limited to, implementation of:

- Discharge checklists
- "Hand off" communication plans with receiving medical and behavioral health providers
- Wellness initiatives targeting high-risk behavioral health patients, such as WRAP, health planning and motivation strategies, Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders,
- Individual and family education initiatives including self-management skills.
- Post-discharge medication planning
- Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.
- Transition and wellness support from certified peer specialists for mental health and /or substance use disorders.

- More intensive follow-through programs, such as CTI or other evidence-informed practices, for individuals with more severe behavioral health disorders and other challenges, such as homelessness.
- Electronic data exchange for critical clinical information to support excellent continuity of care.

2.18 Recruit, train and support consumers of mental health services to provide peer support services

2.18.1 Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.

Required core project components:

a) Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.

b) Conduct readiness assessments of organization that will integrate peer specialists into their network.

c) Identify peer specialists interested in this type of work.

d) Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity.

e) Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.

f) Identify patients with serious mental illness who have health risk factors that can be modified.

g) Implement whole health peer support.

h) Connect patients to primary care and preventive services.

i) Track patient outcomes. Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

2.18.2 In an innovative manner not described above, implement other evidence-based project to recruit, train, and support consumers of mental health services to provide peer support services. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

2.19 Develop Care Management Function that integrates primary and behavioral health needs of individuals

2.19.1 Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients

a) Conduct data matching to identify individuals with co-occurring disorders who are:

- not receiving routine primary care,
- not receiving specialty care according to professionally accepted practice guidelines,

- over-utilizing ER services based on analysis of comparative data on other populations,
- over-utilizing crisis response services.
- Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

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.

c) Identification of BH case managers and disease care managers to receive assignment of these individuals.

d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.

e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma.

f) Train staff in protocols and guidelines.

g) Develop registries to track client outcomes.

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.

2.19.2 In an innovative manner not described above, implement other evidence-based project to develop a care management function that integrates primary and behavioral health needs of individuals. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.

Category 3: Quality Improvements

I. Category 3 Introduction

The overall objective of Category 3 is to assess the effectiveness of Category 1 and 2 interventions. As described in the Program Funding and Mechanics (PFM) Protocol, each project selected in Categories 1 and 2 will have an associated outcome measure from Category 3.

For the purposes of the RHP Planning and PFM Protocols, outcome measures are defined as "*measures that 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.*"

Outcomes in Category 3 consist of Process Milestones during DY2 and DY3 and Improvements Targets beginning no later than DY4. Process milestones will define what activities are undertaken to prepare for measuring and reporting of the outcomes in future years. These activities could include development of the plans to prepare for reporting, establishment of the baselines, and preparing data systems, among other activities.

Outcomes for Category 3 include

- Process Milestones for DY 2 and DY3
- Improvement Targets for DY4 and DY5 (could also be in DY3 for hospital inpatient projects)

The process milestones and improvement targets listed in this category will be specified by the performing provider, tailored to meet the target population and intervention goals of the related Category 1 and 2 projects.

The outcome improvement targets are labeled as stand-alone measures or non-standalone measures. Providers can select among the following methods to meet Category 3 requirements for each Category 1 and 2 project:

- At least one stand-alone measure
- At least one stand-alone measure and additional non-standalone measure(s)
- A combination of at least 3 non-standalone measures

Measures can be selected within or across the Outcome Domains. Cost-related outcomes can be used as the stand-alone outcome only for 2.5 (Cost Containment) projects. Cost outcomes can be non-standalone outcomes for other project areas.

All Category 3 improvement targets listed below are evidence based and nationally endorsed by National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS) or another nationally recognized organization.

Outcomes included in Category 3 for DY4 and DY5 as listed below do not represent an all-inclusive list of outcome measures. Performing providers can propose additional outcomes specific to their projects. The two tables below can be used as a guide for identifying outcome domains as they relate to the Category 1 and 2 project areas.

II. Process Milestones – DY2 and DY3

These are the milestones that the performing provider will report on throughout DYs 2-3. Metrics, data sources, goals and rationale will be specified by the performing provider for each of the process milestones listed below.

- P-3.1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3.2 Establish baseline rates
- P-3.3 Develop and test data systems
- P-3.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- P-3.5 Disseminate findings, including lessons learned and best practices, to stakeholders
- P-3.7 Other activities not described above

III. Improvement Targets – DY4 and DY5 (can also start in earlier years)

Providers will select outcome improvement targets from the list below as they relate to their Category 1 and 2 projects. Providers will specify how the outcome and the Category 1 or 2 projects are related (specifically, why that outcome was identified as the best suited to measure the impact of the Category 1/2 intervention), identify improvement target goals and demonstrate a logical progression between the process milestones above and the outcome selected below.

Category 3 Outcomes are organized into related domains: Primary Care and Chronic Disease Management, Potentially Preventable Admissions, Readmissions and Complications, Cost of Care, Patient Satisfaction, Oral Health, Perinatal Care, Right Care in Right Setting and Patient Centeredness, Functional Status, Health Disparities, Primary Care and Primary Prevention, and Palliative Care. Each domain includes a list of the suggested improvement targets with metrics that contain metric specifications (numerator and denominator, where applicable) that the provider will report according to the schedule and relative to the baseline and prior reporting year, as identified in the PFM Protocol.

Outcome Domains

OD-1- Primary Care and Chronic Disease Management

IT-1.1 **Third next available appointment[1,2]: (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.

a Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.

b 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**
- Exclusions:

[1] http://www.ihi.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx

[2] http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918

- 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.

c Data Source: Appointment management system

d Rationale/Evidence: 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 well have better medical outcomes.

- *Overarching Goals:*
  - Decrease number of days to third next available appointment to zero days (same day) for Primary Care.
  - Decrease number of days to third next available appointment to two days for Specialty Care.
- *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 the "dummy" appointment is requested) to the day of the third available appointment. Some electronic scheduling systems can be programmed to compute the number of days automatically.

IT-1.2 **Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)[3] (Non- standalone measure):**

a Drugs to Identify Members on Digoxin
b Drugs to Identify Members on Diuretics
c Drugs to Identify Members on Anticonvulsants
d Antidepressant Medications

IT-1.3 **Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)[4] (Stand-alone measure)**

a Numerator: Number of patients who had each of the following during the reporting period:

[3] This addresses 4 drug types (using 2012 specifications) – it is then reported as 4 rates – so it is a composite measure. Measure specifications are in development.
http://www.ncqa.org/tabid/1442/Default.aspx
http://www.ncqa.org/LinkClick.aspx?fileticket=O-31v4G27sU%3d&tabid=1415

[4] http://qualitymeasures.ahrq.gov/content.aspx?id=34654

- 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.

b 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.

c Data Source: EMR, Registry

d Rationale/Evidence: 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.

IT-1.4 **Controlling high blood pressure (NCQA-HEDIS 2012)[5] (Stand-alone measure)**

a 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

b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

c Data Source: EMR, Registry

d Rationale/Evidence: 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 hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 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.

IT-1.5 **Depression management[6] (**CMS encourages providers to pick both of the measures below for depression management improvement target**)**

[5] http://qualitymeasures.ahrq.gov/content.aspx?id=34655

- **Screening and Treatment Plan for Clinical Depression (NQF#0418) (Non- standalone measure)**
  - a Numerator:
  - b Denominator:
  - c Data Source:
  - d Rationale/Evidence:

- **Depression Remission at Twelve Months (NQF# 0710)[7] (Stand-alone measure)**
  - a Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
  - b Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
    - Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
  - c Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records
  - d Rationale/Evidence: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.
    The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.
    This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

IT-1.6 Comprehensive diabetes care: (NCQA-HEDIS 2012)[8]

- ***HbA1c poor control (>9.0%)[9]- NQF 0059* (Stand-alone measure)**
  - a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
  - b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
  - c Data Source: EMR, Registry, Claims, Administrative clinical data

- ***BP control (<140/80mm Hg)[10] – NQF 0061 or NQF 0018 can be used instead* (Stand-alone measure)**
  - a 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.

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[6] http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251
[7] http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=55#k=0710
[8] http://www.qualitymeasures.ahrq.gov/content.aspx?id=34666
[9] http://www.htsrec.com/janda/pdf/2012EP_MeasureSpecifications/NQF%200059/NQF_HQMF_HumanReadable_0059.pdf
[10] http://www.qualitymeasures.ahrq.gov/content.aspx?id=34667

b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c Data Source: EMR, Registry, Claims, Administrative clinical data

- ***Retinal eye exam[11]—NQF 0055*** **(Non- standalone measure)**
  a 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
  b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
  c Data Source: EMR, Registry, Claims, Administrative clinical data

- ***Foot exam- NQF 0056*** **(Non- standalone measure)**
  a 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.
  b 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).
  c Data Source: EMR, Registry, Claims, Administrative clinical data.

- ***Microalbumin/Nephropathy- NQF 0062*** **(Non- standalone measure)**
  a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
  b 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).
  c Data Source: EMR, Registry, Claims, Administrative clinical data.

OD-2- Potentially Preventable Admissions

IT-2.1 Congestive Heart Failure (CHF)[12]- PQI #8 (Stand-alone measure)

a Numerator: All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF.
b Denominator: Population in Metro Area or county, age 18 years and older.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

[11] http://www.qualitymeasures.ahrq.gov/content.aspx?id=34661
[12] http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2008%20CHF%20Admission%20Rate.pdf

IT-2.2 End-Stage Renal Disease (ESRD)- ESRD Risk-adjusted admissions for dialysis facility patients (Stand-alone measure) [*this measure is being revised]*

a Numerator: Number of inpatient hospital admissions among eligible patients at the facility during the reporting period.
a Denominator: Number of hospital admissions that would be expected among eligible patients at the facility during the reporting period, given the patient mix at the facility.
b Data Source: EMR, Claims
c Rationale/Evidence: Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital twice a year and hospitalizations account for approximately 36 percent of total Medicare expenditures for dialysis patients (U.S. Renal Data System, 2007). Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost effective health care.

IT-2.3 Hypertension Admission Rate (HTN)[13]- PQI #7 (Stand-alone measure)

a Numerator: All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypertension.
b Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Area[1] or county of the patient residence, not the Metro Area or county of the hospital where the discharge occurred.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

IT-2.4 Behavioral Health/Substance Abuse (BH/SA)- (3M methodology) (Stand-alone measure)

Performing provider should report on both categories below:

1. One for BH/SA as the principal diagnosis; The ranges/intervals/brackets of BH/SA codes as Secondary Diagnosis is following:
    a. Numerator: All discharges for patients aged 18 years and older with a principle or secondary diagnosis of behavioral health or substance abuse (ICD 9 CM categories below).
        i. Behavioral Health codes: 290.X; 293.X-302.X; 306.7-306.9; 307.0-307.1; 307.3-307.7; 307.80, 307.89, 307.9; 308.X-309.X; 310.0, 310.1, 301.9; 311; 312.X – 314.X; 315.0X- 315.2; 315.31-315.34, 315.39; 315.4-315.9; 316-319; 327.X; 388.45; 758.X-758.3X; 759.83; 780.02; 780.1; 780.50, 780.52; 780.54-780.59; 784.6X; 797; 799.2X; 799.51, 799.52, 799.54-799.59; V62.84; V71.0X.
        ii. Substance Abuse codes: 291.X; 292.X; 303.X; 304.X; 305.0X; 305.2X-305.9X; 790.03.
    b. Denominator: Number of residents age 18 and older living in the RHP counties

2. A second category in which a significant BH/SA secondary diagnosis is present (e.g. admission for an accident or diabetes with a secondary diagnosis of psychosis A list of the ranges/intervals/brackets of BH/SA codes as Secondary Diagnosis is following:
    a. Numerator: All discharges for patients aged 18 years and older with a principle or secondary diagnosis of behavioral health or substance abuse (ICD 9 CM categories below).

[13]http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V43/TechSpecs/PQI%2007%20Hypertension%20Admission%20Rate.pdf

i. Behavioral Health & Substance Abuse diagnosis codes: 290.11; 290.3; 390.41-290.43; 290.8-290.9; 291.X; 292.0X-292.84; 292.89; 293.0X-293.84; 294.11, 294.21, 294.8; 295.X; 296.00-296.04; 296.2X-296.4X; 296.50-296.54; 296.6X-296.8X; 298.X; 299.00, 299.80; 300.01-300.02, 300.11, 300.13, 300.21, 300.3, 300.81; 301.51, 301.83; 303.01-303.02, 303.91-303.92; 304.00-304.02, 304.11-304.12, 304.20-304.22, 304.31, 304.40, 304.42, 304.50, 304.70-304.72, 304.80-304.82, 304.91; 305.01, 305.31, 305.41-305.42, 305.51-305.52, 305.61-305.62, 305.71-305.72, 305.81-305.82, 305.91; 307.1, 307.50-307.51; 308.1; 039.81; 312.00, 312.30, 312.34; 318.1-318.2l 348.39; 760.71-760.72; 965.0X, 965.6X; 967.0-967.1; 986.0; 969.1-969.6, 969.8-969.9; 970.1, 970.9; 977.0, 977.3; 995.5X; E950.X; E951.0-E957.1; E952.0-E952.1, E952.9; E953.0-E93.1, E953.9; E955.6, E957.X; V61.21, V62.84.

b. Denominator: Number of residents age 18 and older living in the RHP counties

IT-2.5 Behavioral Health/Substance Abuse (BH/SA)- NQF 0576[14] (Stand-alone measure)

a. Numerator: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

b. 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. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Mental health readmission or direct transfer:
If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

c. Data Source: EMR, Claims

d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
Rate 1. The percentage of members who received follow-up within 30 days of discharge
Rate 2. The percentage of members who received follow-up within 7 days of discharge..

IT-2.6 Behavioral Health/Substance Abuse (BH/SA)- NQF 0105[15] (Stand-alone measure)

a. 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.

[14] http://www.qualityforum.org/QPS/

[15] http://www.qualityforum.org/QPS/

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).

b. 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. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Mental health readmission or direct transfer:
If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

c. Data Source: EMR, Claims
d. Rationale/Evidence: The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.
a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

IT-2.7 Chronic Obstructive Pulmonary Disease (COPD)- [16]PQI 5 (Stand-alone measure)

a Numerator: All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD.
b Denominator: Population in Metro Area or county, age 18 years and older.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

IT-2.8 Adult Asthma Admission Rate[17]- PQI 15 (Stand-alone measure)

[16]http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2005%20Chronic%20Obstructive%20Pulmonary%20Disease%20(COPD)%20Admission%20Rate.pdf
[17]http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V42/TechSpecs/PQI%2015%20Adult%20Asthma%20Admission%20Rate.pdf

a Numerator: All discharges of age 18 years and older with ICD-9-CM principal diagnosis code of asthma.
b Denominator: Population in Metro Area or county, age 18 years and older.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

IT-2.9 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381[18] (Stand-alone measure)

a Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.
b Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91,and 493.92 (excludes 493.20, 493.21 and 493.22)as primary and secondary diagnoses with the dates of service “Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail". This is the measurement period. Total period of our pilot initiative was 24 months. We used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail..
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

IT-2.10 Diabetes Short Term Complication Rate- PQI 1[19] (Stand-alone measure)

a Numerator: All non-maternal/non-neonatal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma)
b Denominator: Population in Metro Area or county, age 18 years and older.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

IT-2.11 Diabetes Long Term Complications Admission Rate- PQI 3[20] (Stand-alone measure)

a Numerator: Discharges age 18 years and older with ICD-9-CM principal diagnosis code for long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified).
b Denominator: Population in Metro Area or county, age 18 years and older.
c Data Source: EMR, Claims
d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

[18] http://www.qualityforum.org/QPS
[19] http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2001%20Diabetes%20Short-term%20Complications.pdf
[20] http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2003%20Diabetes%20Long-term%20Complications%20Admission%20Rate.pdf

IT-2.12 Uncontrolled Diabetes Admissions Rate- PQI 1421(Stand-alone measure)

a Numerator: All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication. Include ICD-9-CM diagnosis codes: 25002 (DM, T2, UNCONT) and 25003 (DM, T1, UNCONT)

b Denominator: Population in Metro Area or county, age 18 years and older.

c Data Source: EMR, Claims

d Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Population in Metro Area or county, age 18 years and older. May be combined with diabetes short-term complications as a single indicator as a simple sum of the rates to form the Health People 2010 indicator (note that the AHRQ QI excludes transfers to avoid double counting cases).

IT-2.13 Preventable admissions for flu and pneumonia (Stand-alone measure) *[under development]*

a Numerator

b Denominator:

c Data Source:

d Rationale/Evidence:.

IT-2.14 Other Admissions Rate [*To be selected by provider*] (Stand-alone measure)

Rationale to include citation and significance of target towards intervention population or community of need.

a Numerator: TBD by performing provider

b Denominator: TBD by performing provider

c Data Source: EMR, Claims

d Rationale/Evidence: Rationale to include citation and significance of target towards intervention population or community of need.

IT-2.15 Ambulatory Care Sensitive Conditions Admissions Rate[22]: (Stand-alone measure)

a Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (see the related "Numerator Inclusions/Exclusions")

- Inclusions
  - Total number of acute care hospitalizations for ambulatory care sensitive conditions* under age 75

    *Based on a list of conditions developed by Billings et al., any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions Chronic obstructive pulmonary diseases Asthma Heart failure and pulmonary edema Hypertension Angina Diabetes

    Note: Refer to the Technical Note: Ambulatory Care Sensitive Conditions (ASCS) document listed in the "Companion Documents" field for codes used.

- Exclusions

[21]http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2014%20Uncontrolled%20Diabetes%20Admission%20Rate.pdf

[22] http://www.qualitymeasures.ahrq.gov/content.aspx?id=27275

- Individuals 75 years of age and older
- Death before discharge

b Denominator: Total mid-year population under age 75
c Data Source: EMR, Claims
d Rationale/Evidence: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care.

IT-2.16 Prevention Quality Indicators (PQI) Composite Measures for Ambulatory Care Sensitive Conditions[23] (Stand-alone measure)

Overall Composite – PQI 90

PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #11 Bacterial Pneumonia Admission Rate
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #13 Angina without Procedure Admission Rate
PQI #07 Hypertension Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #08 Heart Failure Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate
PQI #10 Dehydration Admission Rate	PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes

Acute Composite- PQI 91

PQI #10 Dehydration Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #11 Bacterial Pneumonia Admission Rate	

Chronic Composite- PQI 92

PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #13 Angina without Procedure Admission Rate
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate
PQI #07 Hypertension Admission Rate	PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes
PQI #08 Congestive Heart Failure (CHF) Admission Rate	

a 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.
b Data Source: EMR, Claims

[23]http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V44/Composite_User_Technical_Specification_PQI%20V4.4.pdf

c 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.

As anticipated, areas with higher rates of diabetes and hypertension show higher hospitalizations, particularly in the chronic composite. However, for asthma the contrary relation is true suggesting other confounding factors. Notably in V4.3, the diabetic population serves as the denominator for PQI #01, PQI #03 and PQI #14.

Areas with low levels of poverty also show lower hospitalization rates for each of the PQI composites, which is independent of access to care.

The PQI composites provide the following advantages:

- Provide assessment of quality and disparity
- Provide baselines to track progress
- Identify information gaps
- Emphasize interdependence of quality and disparities
- Promote awareness and change

OD-3 Potentially Preventable Re-Admissions - 30 day Readmission Rates (PPRs)

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.[24] Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. For all individual conditions, admissions for patients that meet any of the following criteria are excluded. These exclusions were originally listed as part of the Heart Failure readmission metric,[25] obtained from the National Quality Forum, and is applied to all other individual-condition metrics for consistency.

- With an in-hospital death (because they are not eligible for readmission);
- Without at least 30 days post-discharge enrollment in Medicare FFS (because the 30-day readmission outcome cannot be assessed in this group;
- Transferred to another acute care facility (When a patient is transferred from one acute care hospital to another, these multiple, contiguous hospitalizations are considered one episode of care. Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute setting);
- Discharged against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge);

[24] 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.

[25] Quality Positioning System (QPS) Measure Description Display Information: Heart Failure. http://www.qualityforum.org/QPS/. Accessed June 5, 2012.

- Admitted with heart failure within 30 days of discharge from an index admission (Admissions within 30 days of discharge of an index admission will be considered readmissions. No admission is counted as a readmission and an index admission. The next eligible admission after the 30-day time period following an index admission will be considered an index admission.)

IT-3.1 All cause 30 day readmission rate- NQF 1789[26] (Stand-alone measure)

a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. We defined a readmission 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.

b 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.
- Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

c Data Source: EMR, Claims

d Rationale/Evidence: This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition 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 (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.

IT-3.2 Congestive Heart Failure 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission (ICD-9-CM codes 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, and 428.xx). 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 HF (ICD-9-CM codes 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, and 428.xx) and with a complete claims history for the 12 months prior to admission.

IT-3.3 Diabetes 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

[26] http://www.qualityforum.org/QPS/

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.

IT-3.4 Renal Disease 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index renal disease 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 renal disease and with a complete claims history for the 12 months prior to admission.

IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index AMI 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 AMI and with a complete claims history for the 12 months prior to admission.

IT-3.6 Coronary Artery Disease (CAD) 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index CAD 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 CAD and with a complete claims history for the 12 months prior to admission.

IT-3.7 Stroke (CVA) 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index CVA 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 CVA and with a complete claims history for the 12 months prior to admission

IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission in which any of the ICD 9 CM codes below are indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.

- Behavioral Health codes: 290.X; 293.X-302.X; 306.7-306.9; 307.0-307.1; 307.3-307.7; 307.80, 307.89, 307.9; 308.X-309.X; 310.0, 310.1, 301.9; 311; 312.X – 314.X; 315.0X-

315.2; 315.31-315.34, 315.39; 315.4-315.9; 316-319; 327.X; 388.45; 758.X-758.3X; 759.83; 780.02; 780.1; 780.50, 780.52; 780.54-780.59; 784.6X; 797; 799.2X; 799.51, 799.52, 799.54-799.59; V62.84; V71.0X.

- Substance Abuse codes: 291.X; 292.X; 303.X; 304.X; 305.0X; 305.2X-305.9X; 790.03.
- Behavioral Health & Substance Abuse diagnosis codes: 290.11; 290.3; 390.41-290.43; 290.8-290.9; 291.X; 292.0X-292.84; 292.89; 293.0X-293.84; 294.11, 294.21, 294.8; 295.X; 296.00-296.04; 296.2X-296.4X; 296.50-296.54; 296.6X-296.8X; 298.X; 299.00, 299.80; 300.01-300.02, 300.11, 300.13, 300.21, 300.3, 300.81; 301.51, 301.83; 303.01-303.02, 303.91-303.92; 304.00-304.02, 304.11-304.12, 304.20-304.22, 304.31, 304.40, 304.42, 304.50, 304.70-304.72, 304.80-304.82, 304.91; 305.01, 305.31, 305.41-305.42, 305.51-305.52, 305.61-305.62, 305.71-305.72, 305.81-305.82, 305.91; 307.1, 307.50-307.51; 308.1; 039.81; 312.00, 312.30, 312.34; 318.1-318.2l 348.39; 760.71-760.72; 965.0X, 965.6X; 967.0-967.1; 986.0; 969.1-969.6, 969.8-969.9; 970.1, 970.9; 977.0, 977.3; 995.5X; E950.X; E951.0-E957.1; E952.0-E952.1, E952.9; E953.0-E93.1, E953.9; E955.6, E957.X; V61.21, V62.84.

b Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse (ICD 9 CM categories above and appendix) and with a complete claims history for the 12 months prior to admission

IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

a Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

IT-3.10 Adult Asthma 30 day readmission rate (Stand-alone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma 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 asthma and with a complete claims history for the 12 months prior to admission.

IT-3.11 Other 30 day readmission rate [*To be selected by provider*] **(Stand-alone measure)**

Rationale to include citation and significance of target towards intervention population or community of need.

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

c Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of [TBD by provider] and with a complete claims history for the 12 months prior to admission.

IT-3.12 Improvement in other targeted PPR rate (as calculated by 3M using risk adjusted methodology) (Stand-alone measure)

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions [*under revision]*

IT-4.1 Improvement in risk adjusted Potentially Preventable Complications rate(s)

a Numerator: Percent change in risk adjusted PPC rate for targeted conditions
b Data Source: TX PPC report, EMR, Claims
c Rationale/Evidence:

IT-4.2 Central line-associated bloodstream infections (CLABSI) rates

a Numerator: Number of cases of CLABSI as designated by IQR criteria[27]
b Data Source: EMR, Claims, IQR/NHSN data
c 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*.

IT-4.3 Catheter-associated Urinary Tract Infections (CAUTI) rates

a Numerator: Number of cases of CAUTI as designated by IQR criteria[28]
b Data Source: EMR, Claims, IQR/NHSN data
a Rationale/Evidence: The urinary tract is the most common site of healthcare-associated infection, accounting for more than 30% of infections reported by acute care hospitals1. Virtually all healthcare-associated urinary tract infections (UTIs) are caused by instrumentation of the urinary tract. CAUTI 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. Prevention of CAUTIs is discussed in the CDC/HICPAC document, *Guideline for Prevention of Catheter-associated Urinary Tract Infections*

IT-4.4 Surgical site infections (SSI) rates[29]

[27] http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
[28] http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf
[29] All reported and collected through CDCs NHSN site with participation in IQR.
http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021

a Numerator: Number of cases of SSI as designated by IQR criteria[30]
b Data Source: EMR, Claims, IQR/NHSN data
a Rationale/Evidence: 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. Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk. A successful surveillance program includes the use of epidemiologically-sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback.[5,6] Recommendations are outlined in the CDC's *Guideline for Prevention of Surgical Site Infection, 1999*.

IT-4.5 Falls

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence:

IT-4.6 Hospital-acquired Deep Vein Thromboses

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence:

IT-4.7 Hospital-acquired Deep pressure ulcers

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence:

OD-5 Cost of Care

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Stand-alone measure for Project 2.5 only. For all other projects it is not a stand-alone measure)

a. 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
b. Data source: TBD by provider as appropriate for analysis type
c. Rationale/evidence: TBD by provider

IT-5.2 Per episode cost of care[31] (Stand-alone measure for Project 2.5 only. For all other projects it is not a stand-alone measure)

[30] http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf?agree=yes&next=Accept

Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including diabetes, congestive heart failure, acute myocardial infarction, asthma, low back pain and many others.

a. Numerator: total cost for episode of care
b. Denominator: total number of episodes in one month
c. Data source: EHR; provider and regional data;
d. Rationale: As health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. Developing cost-of-care measures that can help those who get, give and pay for care understand how different providers use resources and compare them to national benchmarks was one of the TX HHSC DSRIP project's goals.

Relative resource use or costs will require 1 year of enrollment with no more than a 30 day gap in coverage.

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores (*all questions within a survey need to be answered to be a stand-alone 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
(1) are getting timely care, appointments, and information; (**Stand-alone measure**)
(2) how well their doctors communicate; (**Stand-alone measure**)
(3) patient's rating of doctor access to specialist; (**Stand-alone measure**)
(4) patient's involvement in shared decision making, and (**Stand-alone measure**)
(5) patient's overall health status/functional status. (**Stand-alone measure**)

a Numerator: Percent improvement in targeted patient satisfaction domain
b Data Source: Patient survey
c Rationale/Evidence:

OD-7 Oral Health (Select one or more measures)

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)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

[31] http://www.healthqualityalliance.org/userfiles/COC%20draft%20080410.pdf

IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020) (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-7.3 Early Childhood Caries (fluoride applications) (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.

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-7.4 Topical Fluoride application (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.

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-7.5 Proportion of older adults aged 65 to 74 years who have lost all their natural teeth (Healthy People 2020) (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

OD- 8 Perinatal Outcomes (Select one or more measures)

IT-8.1 Timeliness of Prenatal/Postnatal Care[32] (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

a. Numerator: Deliveries of live births for which women receive the following facets of prenatal and postpartum care:
Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

[32] http://www.qualityforum.org/QPS

b. Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year
c. Data source: EMR, claims
d. Rationale: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.
• Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
• Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

IT-8.2 Pre-term Delivery Rate (CHIPRA/NQF # 1382)[33] (Stand-alone measure)

a. Numerator: The number of babies born weighing <2,500 grams at birth
b. Denominator: All births
c. Data source: EMR, claims

IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469)[34] (Stand-alone measure)

a. Numerator: Patients with elective deliveries with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following:
• Medical induction of labor as defined in Appendix A, Table 11.05 available at: http://manual.jointcommission.org
• Cesarean section as defined in Appendix A, Table 11.06 while not in Active Labor or experiencing Spontaneous Rupture of Membranes available at: http://manual.jointcommission.org
b. Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed
    - Exclusions:
      ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
      • Less than 8 years of age
      • Greater than or equal to 65 years of age
      • Length of Stay >120 days
      • Enrolled in clinical trials
a. Data source: EMR, claims
b. Rationale: This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

[33] http://www.qualityforum.org/QPS
[34] http://www.qualityforum.org/QPS

IT-8.4 Antenatal Steroids (Medicaid Adult Core Measure/NQF #476)[35] (Non-standalone measure)

a. Numerator: Patients with a full course of antenatal steroids completed prior to delivering preterm newborns (refer to Appendix B, Table 11.0, antenatal steroid medications available at: http://manual.jointcommission.org)
b. Denominator: Patients delivering live preterm newborns with >=24 and <32 weeks gestation completed
   - Exclusions:
     Less than 8 years of age
     • Greater than or equal to 65 years of age
     • Length of Stay >120 days
     • Enrolled in clinical trials
     • Documented Reason for Not Administering Antenatal Steroid
     • ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for fetal demise as defined in Appendix A, Table 11.09.1 available at: http://manual.jointcommission.org
c. Data source: EMR, claims
d. Rationale: This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).
   .

IT-8.5 Infant Mortality (Stand-alone measure)

a. Numerator: Number of infant deaths during the measurement period
b. Denominator: Number of live births during the time period
c. Data Source: EMR, county vital statistics

OD- 9 Right Care, Right Setting

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons **(Stand-alone measure)**

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

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

- Reduce all ED visits (including ACSC)[36]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[37]

[35] http://www.qualityforum.org/
[36] http://archive.ahrq.gov/data/safetynet/billappb.htm

- 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
        a. Numerator:
        b. Denominator:

c. Data Source: EMR, Claims
d. Rationale/Evidence

OD- 10 Quality Of Life/ Functional Status [38])

IT-10.1 Quality of Life-[39],[40],[41] **(Stand-alone measure)**

a. Demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population.
b. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL.
c. Rationale:

IT-10.2 Activities of Daily Living (Stand-alone measure)

a. Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.
b. Data source: Provider may select a validated assessment tool for activities of daily living. Some examples include the Katz ADL Scale, Lawton IADL Scale[42], Barthal Index of Activities of Daily Living[43] and Bristol Activities of Daily Living Scale (for dementia patients).
c. Rationale:
d.

IT-10.3 Functional status metrics (Stand-alone measure)

Applied Cognition domain[44]:

a. Numerator: Mean change score in applied cognition of patients in a post-acute care setting as assessed using the "Applied Cognition" domain of the Activity Measure for Post-acute Care (AM-PAC)

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[37] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[38] http://www.nihpromis.org/default
[39] http://www.qualitymeasures.ahrq.gov/expert/expert-commentary.aspx?id=16466&search=quality+of+life
[40] http://www.ncbi.nlm.nih.gov/pubmed/10472152
[41] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3349491/
[42] http://son.uth.tmc.edu/coa/FDGN_1/RESOURCES/ADLandIADL.pdf
[43] http://www.healthcare.uiowa.edu/igec/tools/function/barthelADLs.pdf
[44] http://www.qualitymeasures.ahrq.gov/content.aspx?id=27139&search=functional+status

b. Denominator: Patients in the post-acute care setting who were assessed at baseline and at some follow-up point in time using the "Applied Cognition" domain of the Activity Measure for Post-acute Care (AM-PAC)
c. Data source: Patient/Individual survey
d. Rationale/Evidence: Initially, Activity Measure for Post-acute Care (AM-PAC) test items were administered to a large sample of patients from different care settings with different diagnoses. Factor analytic work identified three distinct, interpretable factors that accounted for 72% of the variance: Applied Cognition (44%), Daily Activities (19%) and Basic Mobility (9%). These factors were verified by a confirmatory factor analysis and defined as the three AM-PAC domains. Using Item Response Theory (IRT), items in each domain were scaled along a continuum of item difficulty. Items that were redundant or did not fit the model were eliminated. The remaining items formed the AM-PAC item banks, which included a wide range of items calibrated along a continuum of difficulty.

   Adequate levels of reliability of individual items and validity of the AM-PAC have been established and have been reported. Refer to the articles referenced in the "Evidence for Reliability/Validity Testing" field for further information.

Basic Mobility Domain[45]:

a. Numerator: Mean change score in basic mobility of patients in a post-acute care setting as assessed using the "Basic Mobility" domain of the Activity Measure for Post-acute Care (AM-PAC)
b. Denominator: Patients in the post-acute care setting who were assessed at baseline and at some follow-up point in time using the "Basic Mobility" domain of the Boston University Activity Measure for Post-acute Care (AM-PAC)
c. Data source: Patient/Individual survey
d. Rationale/Evidence

Daily Activities Domain[46]:

a. Numerator: Mean change score in daily activity of patients in a post-acute care setting as assessed using the "Daily Activities" domain of the Boston University Activity Measure for Post-acute Care (AM-PAC)
b. Denominator: Patients in the post-acute care setting who were assessed at baseline and at some follow-up point in time using the "Daily Activities" domain of the Activity Measure for Post-acute Care (AM-PAC)
c. Data source: Patient/Individual survey
d. Rationale/Evidence

IT-10.4 Functional status assessment for knee replacement (ONC 104A) (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

[45] http://www.qualitymeasures.ahrq.gov/content.aspx?id=27137&search=functional+status
[46] http://www.qualitymeasures.ahrq.gov/content.aspx?id=27138&search=functional+status

IT-10.5 Functional status assessment for hip replacement (ONC 104B) (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-10.6 Functional status assessment for complex chronic conditions (ONC 106) (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-10.7 Provider could recommend other measures if they do not have an EHR but they must be evidence based, appropriate for proposed project, and meet the above definition of an outcome measure.

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

OD- 12 Addressing Health Disparities in Minority Populations

IT-12.1 Clinical indicator to be improved and disparity gap to be determined by provider (Stand-alone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-12.2 Target population experiencing poorer health due to the disparity identified (Non-standalone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-12.3 Could select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-stand-alone measures and target a specific minority population with a demonstrated disparity in the particular measure **(Stand-alone measure)**

OD- 13 Primary Care and Primary Prevention

IT-13.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-13.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-13.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-13.4 Pneumonia vaccination status for older adults (HEDIS 2012) (Non-standalone measure)

a Numerator:
b Denominator:
c Data Source: EMR, Claims
d Rationale/Evidence

IT-13.5 Other USPSTF-endorsed screening outcome measures

OD- 14 Other Outcome Measures

IT-14.1 Provider to recommend other related metrics not included above, must be evidence based, appropriate for proposed project, and meet the above definition of outcome measures.

OD- 15 Palliative Care

IT-15.1 Pain assessment (NQF-1637) (Non-standalone measure)

Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.[47]

a. Numerator: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
b. Denominator: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.

[47] http://www.nahc.org/regulatory/HospiceRegs/1637.PDF

- Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

c. Data Source: EMR, Claims
d. Rationale/Evidence: Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

IT-15.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
Percentage of patients with chart documentation of preferences for life sustaining treatments.[48]

a. Numerator: Patients whose medical record includes documentation of life sustaining preferences
b. Denominator: Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
   - Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.
c. Data Source: EMR, Claims
d. Rationale/Evidence: Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

IT-15.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)-
Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.[49]
(Stand-alone measure)

a. Numerator: Patients who died from cancer and had >1 ER visit in the last 30 days of life
b. Denominator: Patients who died from cancer.
c. Data Source: EMR, Claims
d. Rationale/Evidence: Although, when operationalized as a claims-based measure, this does not take patient preferences into account, the idea is for the measure to be seen as an overall indication of practice style and/or available palliative resources. An individual patient experiencing this process of care has not necessarily received poor quality care, but unless there is a reason to think that the patients in one setting have a significantly greater proportion with differing preferences, aggregate rates of the measure can justifiably be compared across settings. In this way it is a reflection of the quality of end-of-life care.

IT-15.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213) - Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. [50]**(Stand-alone measure)**

a. Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life
b. Denominator: Patients who died from cancer.
c. Data Source: EMR, Claims

[48] http://www.nahc.org/regulatory/HospiceRegs/1641-1.PDF
[49] www.qualityforum.org
[50] www.qualityforum.org

d. Rationale/Evidence: Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

IT-15.5 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)

a. Numerator: Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.
b. Denominator: Total number of patient's discharged from hospice or palliative care during the designated reporting period..
c. Data Source: EMR, Claims
d. Rationale/Evidence: One of the unique aspects of hospice care involves a true interdisciplinary approach providing care for both the physical and psychosocial and spiritual needs of the patient and caregiver. Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. This measure will help agencies improve processes for addressing spiritual/religious concerns for patients and families receiving hospice care.

Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

DRAFT

September 14, 2012

[RHP Name]

RHP Lead Contact: ***[RHP Contact Person, Contact Information (address, email, phone number)]***

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Instructions

Each RHP in collaboration with the Intergovernmental Transfer (IGT) Entities and Performing Providers in the region must complete and submit an RHP Plan or at a minimum Pass 1 DSRIP projects to HHSC by October 31, 2012. All sections are required unless indicated as optional.

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

The RHP Plan and Financial Workbook must be submitted as Microsoft Word and Excel files to the waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us.

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

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

Section I. RHP Organization

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

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

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
Anchoring Entity *(specify type of Anchor, e.g. public hospital, governmental entity)*						
IGT Entities *(specify type of government entity, e.g. county, hospital district)*						

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
Performing 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)*						
UC-only Hospitals *(list hospitals that will only be participating in UC)*						
Other Stakeholders *(specify type)*						
County Medical Associations/Societies						
Regional Public Health Directors						
Other significant safety net providers within the region (specify type)						
Others (specify type, e.g. advocacy groups, associations)						

Section II. Executive Overview of RHP Plan

Provide a brief description of the RHP Plan to include, but not limited to, the following:

- *Overarching RHP goals/vision for delivery system transformation over the 5-year period*
- *High-level summary of existing RHP healthcare environment, which may include a brief summary of the RHP's patient population and health system*
- *Key health challenges facing the RHP*
- *High level summary of how the 4-year DSRIP projects realize the RHP's 5-year vision*
- *Complete the summary of Categories 1-2 projects table below for all projects in the RHP Plan. The table is based on projects listed in Section V.*

The narrative in this section described above is limited to 3 pages. The page limit does not apply to the table below.

Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure** (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			
[TPI].1.1 Project Title Provider Name & TPI			
[TPI].1.2 Project Title Provider Name & TPI			
[TPI].1.1 Project Title Provider Name & TPI			
Category 2: Program Innovation and Redesign			
[TPI].2.1 Project Title Provider Name & TPI			
[TPI].2.1 Project Title Provider Name & TPI			
[TPI].2.2 Project Title Provider Name & TPI			

Section III. Community Needs Assessment

Provide a description and supporting data of the existing community needs for the five-year waiver period to include, but not limited to, the following:
Note: These items can be reported/taken from existing community assessments and data sources but must cover the entire region and be no more than five years old.

- *Demographics (e.g. race/ethnicity, gender, language, age, income, education, employment, large employers)*
- *Insurance coverage (e.g. commercial, Medicaid, Medicare, uncompensated)*
- *Description of region's current healthcare infrastructure and environment (e.g. number/types of providers; hospital sizes, services, systems, and costs; Health Professional Shortage Area (HPSA))*
- *A brief description of any initiatives in which providers in the RHP are participating that are funded by the U.S. Department of Health and Human Services. Refer to the Companion Document for a list of applicable federal initiatives.*
- *A brief description of any other relevant delivery system reform initiatives underway in the RHP region.*
- *Projected major changes in items considered in the above five bullets expected to occur during the waiver period of FFY 2012 – FFY 2016*
- *Key health challenges specific to region supported by data (e.g. high diabetes rate, access issues, high emergency department (ED) utilization)*

Section III narrative is limited to 15 pages, including tables and graphs to support the narrative. The page limit does not apply to the summary of community needs table below. Additional supplemental community needs materials may be included in the Addendums.

Identify approach and sources used in preparing the assessment.

Complete the summary of community needs table below summarizing at a high level the community needs with a unique community need identification number and the data source. These should include the community needs that the RHP Plan is intended to address.

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

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1		
CN.2		
CN.3		

Section IV. Stakeholder Engagement

A. RHP Participants Engagement

Provide a description of stakeholder engagement process for Performing Providers that are participating in DSRIP projects and eligible for UC payments. This may include a listing and description of past meetings and activities. Please describe additional outreach efforts with other stakeholders who will not be participating in DSRIP projects under the section, "Public Engagement".

Provide a description of plans for ongoing engagement with Performing Providers and IGT Entities (e.g. quarterly meetings).

B. Public Engagement

Provide a description of public engagement, including the opportunities provided for public input into the development of RHP plans and opportunities for public discussion and review prior to plan submission. Identify the stakeholders/groups engaged, including consumers, hospitals, and other providers in the region that are not Performing Providers. This should include a letter from the county medical society or societies (and may include letters from other stakeholders) describing their participation in the RHP Plan included in the Addendums. If a letter cannot be obtained, please document the process to engage county medical societies.

At a minimum, this must include a description of public meetings that were provided in different areas of the RHP wherein access was available to stakeholders by teleconference, public posting of the RHP Plan, and process for submitting public comment on the RHP Plan.

Provide a description of plans for ongoing engagement with public stakeholders (e.g. publication of reports, quarterly meetings).

Section IV is limited to 5 pages. Any supporting documents may be included in the Addendums.

Section V. DSRIP Projects

NOTE: As HHSC negotiates the RHP Planning Protocol (DSRIP menu) with CMS, this section may change.

A. RHP Plan Development

- *Indicate assigned RHP Tier level, minimum number of projects, and number of projects identified in Pass 1 and Pass 2. Describe the process used to implement Pass 1 and Pass 2. Include the complete list of projects considered in Pass 1 and Pass 2, including those projects not included in the submitted RHP Plan in the addendums.*
- *Based on the community needs assessment, describe the RHP goals. Describe the regional approach for addressing the needs and goals.*
- *Describe the process for evaluating and selecting projects included in the RHP Plan consistent with requirements described in Section VI of the Program Funding and Mechanics Protocol.*
- *Provide a list of Performing Providers and TPIs that are exempt from Category 4 reporting according to the criteria in paragraph 11.e. in the Program Funding and Mechanics Protocol.*
- *Section V.A. is limited to 5 pages.*

B. Project Valuation

Provide a narrative that describes the overall regional approach for valuing each project and rationale (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need), including an explanation why a similar project selected by two Performing Providers might have different valuations (e.g. due to project size, provider size, etc.)

Section V.B. is limited to 2 pages.

C. Category 1: Infrastructure Development

Infrastructure development projects lay the foundation for delivery system transformation through investments in technology, tools, and human resources. Performing Providers participating in Category 1 projects may include hospitals, community mental health centers (CMHCs), local health departments, physician practices affiliated with academic science health centers, and other provider types approved by the State and CMS, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Narrative for each Category 1 Project shall include:

- The narrative for each Category 1 Project is limited to 6 pages.
- **Identifying Project and Provider Information:** [Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.]
- **Project Description:** [Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.]
- **Starting Point/Baseline:** [e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.]
- **Rationale:** [A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services.]
- **Related Category 3 Outcome Measure(s):** [Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures.]
- **Relationship to other Projects:** [A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.]
- **Project Valuation:** [A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.]

Milestones/Metric Table for each Category 1 Project shall include:

- **Identifying Project and Provider Information:** [Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), reference numbers of project option and project component(s) included in the project in RHP Planning Protocol (e.g. 1.1.3 and 1.1.3.a), Performing Provider name/TPI. Indicate the Category 3 Outcome(s), the unique Category 3

Outcome Improvement Target (IT) Identifier(s) that is associated with the project, and reference number of the outcome IT(s) from RHP Planning Protocol.]

- **Milestone bundles**: [List acceptable milestones and metrics (numerator/denominator, as applicable) by year (DYs 2-5) that comprise a project's milestone bundle based on Attachment I, RHP Planning Protocol. Each project shall include at least 1 process milestone and at least 1 improvement milestone over the 4-year period. For each metric, provide the baseline once within the first two years and set metric goals for each year to which the metric is applied. Data sources used to document and verify achievement should also be referenced.]
- **RHP Planning Protocol Reference**: [Include milestone reference number (e.g. P-10) and metric reference number (e.g. P-10.2) from the RHP Planning Protocol.]
- **Incentive Payment Amount**: [Estimated DSRIP funding (maximum DSRIP amount for achieving each milestone) by demonstration year. Milestones for a project within a demonstration year must be valued equally. The milestone DSRIP funding must equal the total DSRIP funding per project per demonstration year as indicated in the electronic workbook.]

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT [TPI].1.1]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 1.X.X]*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G. 1.X.X.X]*	*[PROJECT TITLE]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-Y]: [*Insert specific language for selected milestone, if applicable*] Metric 1 [*RHP PP Metric* – P-Y.Z]: [*Insert specific language for selected metric, if applicable*] Baseline/Goal: [*Insert a data point if applicable, e.g. baseline of 10 physicians, goal of 5% increase in visits*] Data Source: Milestone 1 Estimated Incentive Payment *(maximum amount):* $ *Add more milestones and metrics as applicable*	**Milestone 2** [P-5]: Metric 1 [P-5.1]: Baseline/Goal: Data Source: Milestone 2 Estimated Incentive Payment: $ **Milestone 3** [P-8]: Metric 1 [P-8.1]: Baseline/Goal: Data Source: Milestone 3 Estimated Incentive Payment: $		**Milestone 4** [P-9]: Metric 1 [P-9.1]: Goal: Data Source: Milestone 4 Estimated Incentive Payment: $ **Milestone 5** [I-1]: Metric 1 [I-1.2]: Goal: Data Source: Metric 2 [I-1.4]: Goal: Data Source: Milestone 5 Estimated Incentive Payment: $	**Milestone 6** [I-3]: Metric 1 [I-3.1]: Goal: Data Source: Metric 2 [I-3.3]: Goal: Data Source: Metric 3 [I-3.4]: Goal: Data Source: Milestone 6 Estimated Incentive Payment: $
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $	Year 3 Estimated Milestone Bundle Amount: $		Year 4 Estimated Milestone Bundle Amount: $	Year 5 Estimated Milestone Bundle Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $				

Add additional projects using same format above.

NOTE: The information in the table below will be included in the electronic workbook.

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT [TPI].1.1]	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 1.X.X]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G. 1.X.X.X]***	***[PROJECT TITLE]***				
[RHP Performing Provider involved with this project - Name]						*[RHP Performing Provider - TPI]*	
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)}*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*				
Year 2 (10/1/2012 – 9/30/2013)		**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 DSRIP Funding: $		Year 3 Estimated DSRIP Funding: $		Year 4 Estimated DSRIP Funding: $		Year 5 Estimated DSRIP Funding: $	
Estimated State Match (IGT)							
Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $
Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $

D. Category 2: Program Innovation and Redesign

Program Innovation and Redesign projects emphasize the piloting, testing, and replicating of innovative care models. Performing Providers participating in Category 2 projects may include hospitals, community mental health centers, local health departments, physician practices affiliated with academic science health centers and other provider types approved by the State and CMS, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Narrative for each Category 2 Project shall include:

- The narrative for each Category 2 Project is limited to 6 pages.
- **Identifying Project and Provider Information:** [Include: title of project, unique RHP project identification number (e.g. 2.1), Performing Provider name/TPI.]
- **Project Description:** [Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.]
- **Starting Point/Baseline:** [e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.]
- **Rationale:** [A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components were not included), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services.]
- **Related Category 3 Outcome Measure(s):** [Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures.]
- **Relationship to other Projects:** [A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.
- **Project Valuation:** [A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.]

Milestones/Metric Table for each Category 2 Project shall include:

- **Identifying Project and Provider Information:** [Include: title of project, unique RHP project identification number (e.g. [TPI].2.1), reference numbers of project option and project component(s) included in the project in RHP Planning Protocol (e.g. 2.2.3 and 2.2.3.a), Performing Provider name/TPI. Indicate the Category 3 Outcome(s), the unique Category 3

Outcome Identifier(s) that is associated with the project, and reference number of the outcome(s) from RHP Planning Protocol.]

- **Milestone bundles**: [List acceptable milestones and metrics (numerator /denominator as applicable) by year (DYs 2-5) that comprise a project's milestone bundle based on Attachment I, RHP Planning Protocol. Each project shall include at least 1 process milestone and at least 1 improvement milestone over the 4-year period. For each metric, provide the baseline once within the first two years and set metric goals for each year to which the metric is applied. Data sources used to document and verify achievement should also be referenced.]
- **RHP Planning Protocol Reference**: [Include milestone reference number (e.g. P-7) and metric reference number (e.g. P-7.1) from the RHP Planning Protocol.]
- **Incentive Payment Amount**: [Estimated DSRIP funding (maximum DSRIP amount for achieving each milestone) by demonstration year. Milestones for a project within a demonstration year must be valued equally. The milestone DSRIP funding must equal the total DSRIP funding per project per demonstration year as indicated in the electronic workbook.]

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.1]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 2.X.X]*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]*	*[PROJECT TITLE]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-Y]: [*Insert specific language for selected milestone if applicable*] Metric 1 [*RHP PP Metric* – P-Y.Z]: [*Insert specific language for selected metric if applicable*] Baseline/Goal: [*Insert a data point if applicable, e.g. baseline of 500 eligible patients, goal of 7% increase in program enrollment*] Data Source: Milestone 1 Estimated Incentive Payment (*maximum amount)*: $ *Add more milestones and metrics as applicable*	**Milestone 2** [P-5]: Metric 1 [P-5.1]: Baseline/Goal: Data Source: Metric 1 [P-5.3]: Baseline/Goal: Data Source: Milestone 2 Estimated Incentive Payment: $ **Milestone 3** [P-8]: Metric 1 [P-8.1]: Baseline/Goal: Data Source: Milestone 3 Estimated Incentive Payment: $		**Milestone 4** [P-9]: Metric 1 [P-9.1]: Goal: Data Source: Milestone 4 Estimated Incentive Payment: $ **Milestone 5** [I-1]: Metric 1 [I-1.2]: Goal: Data Source: Metric 2 [I-1.4]: Goal: Data Source: Milestone 5 Estimated Incentive Payment: $	**Milestone 6** [I-3]: Metric 1 [I-3.1]: Goal: Data Source: Metric 2 [I-3.3]: Goal: Data Source: Metric 3 [I-3.4]: Goal: Data Source: Milestone 6 Estimated Incentive Payment: $
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $	Year 3 Estimated Milestone Bundle Amount: $		Year 4 Estimated Milestone Bundle Amount: $	Year 5 Estimated Milestone Bundle Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $				

Add additional projects using same format above

NOTE: The information in the table below will be included in the electronic workbook.

<table>
<tr><td>[Unique Category 2 Project Identifier, e.g. Project [TPI.2.1]</td><td>[Reference number of Project Option from RHP PP – e.g. 2.X.X]</td><td>[Reference Number of Project Component(s) from RHP PP - e.g. 2.X.X.X]</td><td colspan="5">[Project Title]</td></tr>
<tr><td colspan="6">[RHP Performing Provider involved with this project - Name]</td><td colspan="2">[RHP Performing Provider - TPI]</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>[unique Category 3 IT identifier(s)]</td><td>[Reference number(s) from RHP PP]</td><td colspan="5">[Outcome Measure (Improvement Target) Title(s)]</td></tr>
<tr><td colspan="2">Year 2
(10/1/2012 – 9/30/2013)</td><td colspan="2">Year 3
(10/1/2013 – 9/30/2014)</td><td colspan="2">Year 4
(10/1/2014 – 9/30/2015)</td><td colspan="2">Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td colspan="2">Year 2 Estimated DSRIP Funding: $</td><td colspan="2">Year 3 Estimated DSRIP Funding: $</td><td colspan="2">Year 4 Estimated DSRIP Funding: $</td><td colspan="2">Year 5 Estimated DSRIP Funding: $</td></tr>
<tr><td colspan="8">Estimated State Match (IGT)</td></tr>
<tr><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td></tr>
<tr><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td><td>Source of State Match (list specific public entity and TIN):</td><td>Estimated Available State Match: $</td></tr>
</table>

E. Category 3: Quality Improvements

NOTE: This section is currently under CMS negotiation and is likely to change.

The goal of Category 3 is to assess an outcome of a project implemented under Category 1 or 2. As described in the Program Funding and Mechanics Protocol, each Category 1 and 2 project is required to have an associated Category 3 outcome measure.

Narrative for each Category 3 Outcome Measure shall include:

- The narrative for each Category 3 Outcome Measure is limited to 3 pages.
- **Identifying Outcome Measures and Provider Information:** [Include: title of outcome measure (improvement target), unique RHP outcome identification number(s) (e.g., [TPI].3.1), Performing Provider name/TPI.]
- **Outcome Measure Description:** [Describe outcome measure, specifically process milestones and selected outcome improvement target(s) for each year (e.g., improve by 5% by end of waiver).]
- **Rationale:** [A narrative describing the reasons for selecting the process milestones and outcome improvement targets. If improvement targets are not determined, please indicate that outcome improvement targets will be determined in DY 2 for implementation in DY 3.]
- **Outcome Measure Valuation:** [A narrative that describes the approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets) and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding).]
- If a project includes more than one outcome measure, complete the entire Section E. (narrative and table) for each outcome measure.

Process Milestones/Outcome Improvement Targets Table(s) for each Category 3 Outcome Measure shall include:

- **Identifying Outcome and Provider Information:** [Include: title of outcome measure (improvement target), unique RHP outcome identification number (e.g., [TPI].3.1), reference number of outcome improvement target in RHP Planning Protocol (e.g. 3.IT-1.1), Performing Provider name/TPI. Indicate the related Category 1 or 2 projects with the unique project identifier (e.g. [TPI].1.3).]
- **Starting Point/Baseline (if applicable):** [e.g., number of ED visits, most recent 30-day PPR rate for Congestive Heart Failure]
- **Process Milestones/Outcome Improvement Targets**: List acceptable process milestones and outcome improvement targets by year (DYs 2-5) that comprise an outcome measure based on Attachment I, RHP Planning Protocol. For each outcome measure, provide the baseline once within the first two years; process milestones in DYs 2 and/or 3, as applicable; and outcome improvement targets beginning no later than DY 4. Data sources used to document and verify achievement should also be referenced.
- **RHP Planning Protocol Reference**: Include process milestone reference numbers (e.g., P-1) and outcome improvement target reference numbers (e.g., OD-5.1) from the RHP Planning Protocol.
- **Incentive Payment Amount**: Estimated DSRIP funding (maximum DSRIP amount for achieving each process milestone/outcome improvement target) by demonstration year. The process milestone/outcome improvement target DSRIP funding must equal the total DSRIP funding per outcome per demonstration year as indicated in the electronic workbook.

[Unique Category 3 outcome measure identifier(s], e.g. [TPI].3.1}	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]*	*[Outcome Measure (Improvement Target) Title]*	
[RHP Performing Provider involved with this project - Name]			*[RHP Performing Provider - TPI]*
Related Category 1 or 2 Projects:	*[Unique Category 1 or 2 project identifier(s), e.g. [TPI].1.4, [TPI].2.3]*		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*] Data Source: Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **Process Milestone 2** [P-2]: Data Source: Process Milestone 2 Estimated Incentive Payment: $ *Add more process milestones/improvement targets, as applicable*	**Process Milestone 3 [P-4]** Data Source: Process Milestone 3 Estimated Incentive Payment: $ **Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Data Source: Outcome Improvement Target 1 Estimated Incentive Payment*:* $	**Outcome Improvement Target 2** [IT-1.1]: Improvement Target: Data Source: Outcome Improvement Target 2 Estimated Incentive Payment*:* $	**Outcome Improvement Target 3** [IT-1.1]: Improvement Target: Data Source: Outcome Improvement Target 3 Estimated Incentive Payment*:* $
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $	Year 3 Estimated Outcome Amount: $	Year 4 Estimated Outcome Amount: $	Year 5 Estimated Outcome Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

NOTE: The information in the table below will be included in the electronic workbook.

[Unique Category 3 outcome measure identifier(s], e.g. [TPI].3.1}		*[Outcome Measure Reference number from RHP Planning Protocol, e.g. 3.X.X]*		*[Outcome Measure (Improvement Target) Title]*			
[RHP Performing Provider involved with this project - Name]						*[RHP Performing Provider - TPI]*	
Related Category 1 or 2 Projects:		*[Unique Category 1 or 2 project identifier(s), e.g. [TPI].1.4, [TPI].2.3]*					
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 DSRIP Funding: $		Year 3 Estimated DSRIP Funding: $		Year 4 Estimated DSRIP Funding: $		Year 5 Estimated DSRIP Funding: $	
Estimated State Match (IGT)							
Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $
Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $	Source of State Match *(list specific public entity and TIN):*	Estimated Available State Match: $

F. Category 4: Population-Focused Improvements (Hospitals only)

Population-focused improvements are "pay for reporting" measures reported by hospitals that demonstrate the impact of delivery system reform investments made under the demonstration. With limited exceptions, all hospital Performing Providers shall report on all Category 4 population-focused improvement measures described in Attachment I: RHP Planning Protocol and categorized in five domains:

Domain A: Potentially Preventable Admissions (8 measures)
Domain B: Potentially Preventable Readmissions – 30 days (7 measures)
Domain C: Potentially Preventable Complications (64 measures)
Domain D: Patient-Centered Healthcare (2 measures)
Domain E: Emergency Department (1 measure)

For each Performing Provider, the following information should be included:

- Performing Provider involved with Category 4 (including TPI).
- **Domain Descriptions:** A description of how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3. Include a description of the expected improvements in each Category 4 domain for DYs 2-5. (Note: Category 4 does not require demonstrating improvements to be eligible for DSRIP payments.) The description for each domain for each hospital is limited to 2 pages.
- **Domain Valuation:** A narrative that describes the approach for valuing each domain and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.]
- **Category 4 Table:** A table of the Category 4 measures the Performing Provider will report on by domain; estimated DSRIP funding (maximum DSRIP amount for reporting a domain), estimated available State match for reporting on a domain, and IGT entity(s) providing non-federal share of funding for reporting domain (including TIN) by demonstration year. In addition to this information, the RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure. A sample table is provided below.
    - DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.
    - Category 4 reporting shall begin in DY 3 for Domains A, B, D, and E, in DY 4 for Domain C, and continue for all Domains through DY 5.

Category 4: Population-Focused Measures *[Insert Hospital Name/TPI]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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 A, B, D, and E.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains C.		
Estimated Maximum Incentive Amount	$	$		
Estimated Available State Match: $	$	$		
Source of State Match *(list specific public entity and TIN):*				
Domain A: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain A - Estimated Maximum Incentive Amount		$	$	$
Estimated Available State Match: $		$	$	$
Source of State Match *(list specific public entity and TIN):*				
Domain B: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain B - Estimated Maximum Incentive Amount		$	$	$
Estimated Available State Match: $		$	$	$
Source of State Match *(list specific public entity and TIN):*				
Domain C: Potentially Preventable Complications (PPCs) - Includes a list of 64 measures identified in the RHP Planning Protocol. Hospitals must report on all or subset of these measures.				
Planned Reporting Period: 1 or 2				
Domain C - Estimated Maximum Incentive Amount			$	$
Estimated Available State Match: $			$	$

Category 4: Population-Focused Measures *[Insert Hospital Name/TPI]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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 of State Match *(list specific public entity and TIN):*				
Domain D: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain C - Estimated Maximum Incentive Amount		$	$	$
Estimated Available State Match: $		$	$	$
Source of State Match *(list specific public entity and TIN):*				
Domain E: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain C - Estimated Maximum Incentive Amount		$	$	$
Estimated Available State Match: $		$	$	$
Source of State Match *(list specific public entity and TIN):*				
Grand Total Payments Across Domains A-E	$	$	$	$

Repeat table for every hospital reporting Category 4 measures

Section VI. Allocation of Funds

NOTE: All tables in this section will be generated from the electronic workbook.

DY 1 DSRIP Allocation by Anchor and Performing Provider

Provide the amount of DY1 DSRIP and estimated state match (IGT) for each Anchor and Performing Provider according to the PFM Protocol, paragraph 24.

	Total DSRIP Amounts for Projects in DYs 2-5	DY 1 DSRIP Amount	Estimated Available State Match (IGT) for DY 1 DSRIP	Source of State Match for DY 1 DSRIP (list specific public entity and TIN)
Anchor				
[Name of Anchor and TPI]				
Performing Providers				
[Name of Performing Provider and TPI]				

Allocations by Performing Provider and UC Hospitals

*Provide the amount of UC, DSRIP, and estimated state match (IGT) for each **Performing Provider** for DYs 2-5. **Add additional tables for each RHP Performing Provider.** For hospitals that are participating in UC and not implementing DSRIP projects, provide the amount of UC and estimated state match (IGT) for each UC hospital.*

[Name of Performing Provider or UC-only Hospitals receiving pool payments]	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Uncompensated Care (UC)				
Total Estimated Maximum UC				
Estimated Available State Match (IGT) for UC				
Source of State Match for UC *(list specific public entity and TIN)*:				
DSRIP				
Category 1				
[List RHP Project Identification Number]				
Category 2				
[List RHP Project Identification Number]				
Category 3				
[List RHP Outcome Identification Number]				
Category 4				
Domain A: PPAs				
Domain B: PPRs				
Domain C: PPCs				
Domain D: Patient-Centered Healthcare				
Domain E: Emergency Department				
Percent DSRIP Payments to Categories 1 & 2				
Percent DSRIP Payments to Category 3				
Percent DSRIP Payments to Category 4				
Total Maximum DSRIP				
Estimated Available State Match (IGT) for DSRIP				
Individual Performing Provider Totals				
TOTAL MAXIMUM UC AND DSRIP				
Total Estimated Available State Match (IGT)				

Estimated IGT Funding

Provide the amount of estimated state match (IGT), UC payments, and DSRIP payments per year for each Performing Provider by IGT entity. Add additional rows as needed.

		DY1 (FFY2012)		
Governmental Entity (IGT Entity)	**Performing Provider**	**IGT ($)**	**UC ($)**	**DSRIP ($)**

		DY2 (FFY2013)		
Governmental Entity (IGT Entity)	**Performing Provider**	**IGT ($)**	**UC ($)**	**DSRIP ($)**

		DY3 (FFY2014)		
Governmental Entity (IGT Entity)	**Performing Provider**	**IGT ($)**	**UC ($)**	**DSRIP ($)**

		DY4 (FFY2015)		
Governmental Entity (IGT Entity)	**Performing Provider**	**IGT ($)**	**UC ($)**	**DSRIP ($)**

		DY5 (FFY2016)		
Governmental Entity (IGT Entity)	**Performing Provider**	**IGT ($)**	**UC ($)**	**DSRIP ($)**

RHP Totals

Provide the summary totals for the RHP for UC and DSRIP, percent allocation of funding between UC and DSRIP, and estimated state match (IGT).

	Year 1	Year 2	Year 3	Year 4	Year 5
Uncompensated Care (UC)					
Total Maximum UC					
Delivery System Reform Incentive Payment (DSRIP)					
Submission of RHP Plan					
Category 1					
Category 2					
Category 3					
Category 4					
Total Maximum DSRIP					
TOTAL MAXIMUM UC AND DSRIP					
UC/DSRIP Allocation					
UC % of Total					
DSRIP % of Total					
State Match (IGT)					
Estimated Available State Match (IGT)					

Section VII. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document;
- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization

Section VIII. 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*