Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

I. Introduction

The Texas 1115 Waiver terms and conditions state that the program of activity funded by the Delivery System Reform Incentive Payment (DSRIP) pool shall be based in Regional Healthcare Partnerships (RHPs) that are directly responsive to the needs and characteristics of the populations and communities composing the RHP. In collaboration with participating providers, the RHP plan will be rooted in intensive learning and sharing that will accelerate meaningful improvement within the providers participating in the RHP. The RHP participants' proposals must flow from the RHP plans and be consistent with the shared mission and quality goals within the RHP, as well as the Centers for Medicare and Medicaid's (CMS) overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes); better health for the population; and lower cost through improvement (without any harm whatsoever to individuals, families, or communities).

The waiver and DSRIP projects will support providers to position themselves to be competitive in the emerging healthcare marketplace in which data-based quality performance and cost-efficiency drive competition. Through the waiver, RHPs and DSRIP performing providers can invest in transforming their capacities to:

- Participate in integrated systems of care in which the elements of the system function together in a highly effective manner on an individual and population basis and where patients can receive the right care at the right time in the right setting;
- Offer timely, proactive, coordinated medical home care from a multi-disciplinary team that is highly adept at managing chronic disease;
- Provide patients with positive health care experiences;
- Deliver proactive and planned prevention and primary care services for all patients, and expand the primary care workforce to increase capacity and enable increased patient access;
- Deliver high-quality care and be an engine for ongoing improvement in quality, safety, and efficiency; and
- Provide equitable care and an equitable opportunity for health that is tailored to patient-specific health care needs, desires, and backgrounds in a respectful manner.

In order to achieve this vision, the RHP plans include Population-focused Improvement (Category 4) and Quality Improvements (Category 3). This work is enabled and bolstered by a broad array of projects related to Innovation and Redesign (Category 2) and Infrastructure Development (Category 1).

This document includes the improvement projects for DSRIP Categories 1-4, that RHP participants may choose to include in their plans. The projects demonstrate the focus areas, milestones, and metrics represented by the RHPs' plans. Each RHP plan will provide the rationale for focusing on the particular projects, milestones, and metrics most relevant to the RHP's population and circumstances. The measures are evidence-based and vetted by nationally-recognized organizations when possible.

The example milestones and metrics listed under projects included in this document are not meant to be adopted by every Performing Provider that chooses that improvement project, but rather demonstrates the use of a "menu set" to arrive at a comprehensive array of potential improvement activities and ways to measure progress. However, it is important to note that the overall undergirding of the interventions (i.e., the models and constructs) is similar across all RHP plans.

Together, these plans, and the delivery system transformation they describe, will prepare Texas RHPs to position themselves for the emerging healthcare market and to pursue the triple aim.

Interconnection and Shared Orientation of Improvement Projects:

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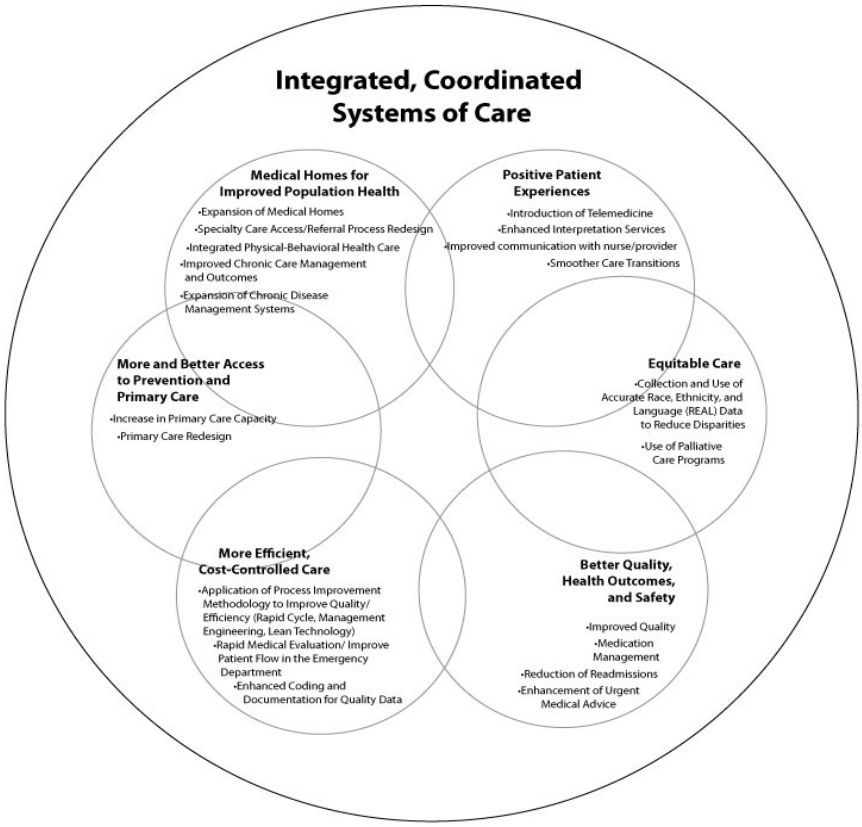
The diagram below demonstrates the interconnection of the improvement projects pursued by RHPs with an overall goal of becoming more competitive, more effective, and higher quality providers of care, by underscoring:

- While they are highly related projects, each improvement project is distinct;
- All of the proposed improvement projects are oriented to creating more effective and coordinated care provision; and
- The coordinated approach to supporting improved patient experience, population health, and cost control.

For purposes of space, the bullet points in the below diagram represent *select*, but not all, Categories 1-4 improvement projects to demonstrate that multiple, complementary initiatives will be occurring in the same RHP simultaneously, reinforcing each other in the transformation of care delivery:



The following pages include the comprehensive Categories 1-4 improvement projects.

II. Required Plan Elements

- Based on this project list and the *Program Funding and Mechanics Protocol* (Attachment J), RHPs will submit four-year RHP plans that describe: (1) the reasons for the selection of the projects, based on gaps, needs, and key challenges; (2) how the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform

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relevant to the patient population; and (3) the progression of the project year over year, including the specifics and exact data source needed per project per measure per metric per year.

- Categories 1-2 each include several projects, from which RHP participants will select at their option (please see the following pages). Each RHP must choose a total number of projects from each category in accordance with the *Program Funding and Mechanics Protocol*.
    - Each project includes multiple potential Process Measures (process-oriented) and Improvement Measures (results-oriented) from which RHP participants would choose at least one Process Measure and one Improvement Measure. It should be noted that although most Process Measures have one metric, several projects may be carried out by a given Performing Provider simultaneously, with the result that a series of related metrics will apply.
    - For each project selected for Categories 1-2, RHP plans must include a robust narrative that includes the following subsections:
        - The Goal(s) for the project, which describes: (1) the specific challenge(s) faced by the RHP, such as a specific gap, need, or issue; (2) the major delivery system solution(s) identified to address the challenge(s) by implementing the particular project, including explaining how the project will work to fill the gap/need or solve the issue; (3) the starting point of the Performing Provider related to the project, such as a benchmark, if one exists, and/or the baseline on or around December 1, 2011, for the Improvement Measures; and (4) the overall target goal and the significance of that goal to the Performing Provider, the RHP, and patients. As part of this subsection, each Performing Provider will provide its reasons for selecting the project, milestones, metrics, improvements, and targeted goals based on relevancy to the Performing Provider's population and circumstances, community need, and Performing Provider's priority and starting point.
        - Related Projects, which describes how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. For example, a plan may include the project to Expand Primary Care Capacity in Category 1, and the projects Expanding the Medical Home Model and Redesigning Primary Care in Category 2. The plan could describe how expanding primary care capacity was related to being able to expand the medical home model and redesign primary care, which could be occuring in the same clinics, if applicable. Finally, in this component, the plan would, for example, describe how all of these projects in sum are critical to being able to improve care outcomes, as measured in Category 4. This is because the capacity, access, and efficiency attained in the primary care clinics – along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner – are foundational to bringing in the right patients at the right time to make sure planned, proactive, and organized care is delivered.

- In addition to the narrative, the plan will include a Milestones and Metrics Table for each Category 1-2 project.
    - All projects must include specific, measurable milestones based on projects, measures, metrics, and data sources selected from or otherwise in accordance with this document.

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- The milestones shall be designated by project by year in table format.
- For each milestone, the RHP plan must include metric(s) selected from this protocol document.
- Even though the measure may be selected for more than one year, in each year, the milestone will be uniquely specified to include the particular improvement and specific data source(s) for that year.

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III. Sample Project

The RHP plans for Categories 1-2 would resemble the sample project below:

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Primary Care Redesign: Sample Project Narrative

- **Goal:** We currently have about 1,800 patients waiting for primary care medical home appointments. It may be difficult for the patient to get a primary care appointment in a timely manner due to traditional office hours and the practice of medicine structured around the physician, not around the patient. In order to address this challenge, Public Hospital A will redesign primary care to achieve increased efficiencies to maximize the capacity we already have. This plan seeks to build upon work we have started to standardize clinic-level data across Public Hospital System A so that we can better understand cycle time, wait times for primary care, and patient satisfaction. In order to do this, we propose to: (1) Build internal capacity with the resources we already have through implemented efficiencies that will reduce primary care cycle times, patient no-show rates, and days to third next available appointments; and (2) Implement the Patient Centered Scheduling Model so that patients can get in to see their primary care team when needed and when it is convenient for the patient to enable expanded access to primary care. Historically at Public Hospital System A, patient appointment "no-show" rates have been as high as 30%.

- **Expected Result:** Patient "no-show" to appointment rate is less than 10% as a result of improved access when it is convenient for the patient, and due to establishing an ongoing relationship with his/her care team that reinforces continuity of care.

- **Relation to Category 4 Population-focused Improvement:** With increased access to primary care, patients are better able to receive preventive, primary, and ongoing care, developing a continuity of care with their primary care team and improved care outcomes.

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Year 1	Year 2	Year 3	Year 4	Related Projects
1. **Milestone:** Develop a plan to build capacity into primary care team schedules, including use of the Patient Centered Scheduling Model and resourcing and training staff in order to reduce patient appointment "no-show" rates • **Metric:** Documentation of the plan, including workplan and timeframes.	2. **Milestone:** Achieve at least a 25% or lower patient no-show rate for primary care medical homes[1] due to enhanced continuity of care and lasting relationships established between the provider and the patient • **Metric:** No-show rate o **Numerator:** Number of patients who missed an appointment in a medical home session o **Denominator:** Number of patients scheduled for each session	3. **Milestone:** Achieve at least a 12% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate o **Numerator:** Number of patients who missed an appointment in a medical home session o **Denominator:** Number of patients scheduled for each session	4. **Milestone:** Achieve at least a 10% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate o **Numerator:** Number of patients who missed an appointment in a medical home session o **Denominator:** Number of patients scheduled for each session	• Improve Care Outcomes (Cat. 4) • Reduce Readmissions (Cat. 4)

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[1] For this and other milestones using this measure, measurement is determined based on the percentage of the patients scheduled for each session who did not show up for their medical home visit. The rate is an average measured monthly. This measurement would be based on the most recent reporting month.

IV. Explanation of the Format of this Document

As illustrated above, each RHP will follow the guidelines in this document and provide specificity in its plan. The Categories 1-2 projects include the following components, which provide instruction to the RHPs on what to include in the plan:

- **Goal of Project:** This component describes the purpose of the project. RHP plans will include a narrative description on this component that is specific to the Performing Provider's starting point, particular circumstances, and patients' needs.
- **Project Options:** This component describes the options for high-level activities that the RHP may undertake in order to accomplish the described goals for the project in their plans.
- **Related Projects:** In order to demonstrate clearly the Interconnection and Shared Orientation of Improvement Projects (see page 2 above), this component describes how the project supports and reinforces other projects/interventions. This component underscores that the projects selected by the RHP are inter-related and occur simultaneously, often by the same providers. This component will also describe how the Categories 1-2 projects are foundational to the success of work in Categories 3-4.
- **Key Measures:** This component includes the measures from which the RHP participants will choose:
  - **Process Measures:** These measures are important process steps leading toward process results.
  - **Improvement Measures:** These measures are the process (as opposed to clinical) results of the project.
  - **Metrics:** There are one or more metrics associated with each measure that provide the standards by which the measures are assessed. The RHP will include in its plan the specific targets of the metric.
    - The metric may vary over the life of the project; for example, the targeted patient appointment 'no-show' rate as a result of primary care redesign may be specified as 12% for DY 3 and less than 10% for DY 4 (the goal is to lower the rate).
    - The RHP participants may tailor the targets in the metric, as appropriate.
  - **Data Source:** The data source often lists multiple sources that could be used for the data being measured. Please note that these options identify appropriate sources of information, but as allowed, Performing Providers may identify alternative sources that are more appropriate to their individual systems and that provide comparable or better information. The RHP plans will specify the exact data source being used for the metric each year; for example, if an Performing Provider is expanding health care interpretation, the data source in DY 2 may be submission of the expansion plan. In DY 3, the data source may be documentation of training six additional health care interpreters. In other words, the data source must be specific to the metric being used for that year.
  - **Rationale/Evidence:** This describes why the metric is reasonable, including academic citations, descriptions of how widely used the metric is in the industry, and other reasons why the metric is seen as the appropriate data to meaningfully measure improvement.

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Additional Measures

In an effort to avoid repetition, it is permissable for each project to include any one of the following as measures, in addition to or in lieu of the other measures listed. Each is in the spirit of continuous improvement and applying and sharing learning. If a Performing Provider elects to use one or more of these measures, the RHP plan would describe the related specifics for the measure, such as the metric and data source:

a. Process Measures:
   i. Participate in a collaborative (e.g., in DY 2, join the Hospital Engagement Network, as documented by the appropriate participation document)
   ii. Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs (e.g., in DY2, conduct a gap analysis of high-impact specialty services to identify those in most demand by the local community in order to expand specialty care capacity targeted to those specialties most needed by patients)
   iii. Pilot a new process and/or program
   iv. Assess efficacy of processes in place and recommend process improvements to implement, if any (e.g., in DY 4, evaluate whether the primary care redesign methodology was as effective as it could be, by: (1) performing at least two team-based Plan-Do-Study-Act workshops in the primary care clinics; (2) documenting whether the anticipated metric improvements were met; (3) identifying opportunities, if any, to improve on the redesign methodology, as documented by the assessment document capturing each of these items)
   v. Redesign the process in order to be more effective, incorporating learnings (e.g., in DY 4, incorporate at least one new element into the process based on the assessment, using the process modification process to include the specificity needed as new learnings are discovered in DY 3)
   vi. Implement a new, improved practice piloted in one or more Performing Providers within an RHP (e.g., in DY 5, implement improved practices across the Performing Provider's ambulatory care setting)
   vii. Share learnings from implementing process improvements, such as through presentations, reporting, etc. (e.g., in DY 3, present the results and findings from the redesign work to at least two peer organizations and/or convenings of peer organizations, as documented by the presentation delivered and the agenda)
   viii. Establish a baseline, in order to measure improvement over self
   ix. Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infastructure development or program/process redesign (e.g., in DY 2, complete a planning process for a care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care)
   x. Designate/hire personnel or teams to support and/or manage the project/intervention
   xi. Implement, adopt, upgrade, or improve technology to support the project
   xii. Develop a new methodology, or refine an existing one, based on learnings
   xiii. Incorporate patient experience surveying

b. Improvement Measure: Report on / Improve patient satisfaction/experience (e.g., in DY 5, improve primary care clinic patient satisfaction scores as a result of redesigning clinic visits)

V. Categories 1-4 Projects

The Categories 1-4 Projects follow.

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Category 1 Improvement Projects

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Per the Texas Section 1115 Waiver Terms and Conditions, the purpose of Category 1: Infrastructure Development is "investments in technology, tools and human resources that will strengthen the ability of providers to serve populations and continuously improve services." Therefore, Category 1 would include infrastructure development, including investment in people, places, processes and technology. This category is foundational to the success of Categories 2-4. RHP plans must describe how the infrastructure development will enhance capacity to conduct, measure, and report on quality/performance improvement, expand access to meet demand, and/or enable improved care with strong emphasis on building coordinated systems that promote preventive, primary care.

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The following improvement projects, as specified, would be acceptable for RHPs to include in their Category 1 plans.

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1. Expand Primary Care Capacity

- Goal of Project: Expand the capacity of primary care to better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting

- Project Options:
  - Establish more primary care clinics
  - Expand primary care clinic space
  - Expand primary care clinic hours
  - Expand primary care clinic staffing
  - Expand primary care clinic staffing knowledge
  - Expand urgent care services
  - Expand transportation
  - Expand mobile clinics

- Key Measures:
  - **Process Measures:**
    - i. Measure: Establish additional/expand existing/relocate primary care clinics
      1. Metric: Number of additional clinics or expanded hours or space
         a. Documentation of expansion
         b. Data Source: New primary care schedule or other Performing Provider document
         c. Rationale/Evidence: It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHPs are in real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.
    - ii. Measure: Implement/expand a community/school-based clinics program
      1. Metric: Number of additional clinics or expanded hours or space
         a. Documentation of expansion
         b. Data Source: New primary care schedule or other document
         c. Rationale/Evidence: Providing clinics in the community and/or in schools has been shown to be effective because the health care is located conveniently for patients, and is in a setting that is familiar and may feel 'safe'.
    - iii. Measure: Implement/expand a mobile health clinic program
      1. Metric: Number of additional clinics or expanded hours or space
         a. Documentation of expansion
         b. Data Source: New primary care schedule or other document
         c. Rationale/Evidence: Many RHP plans cover very large counties, including hundreds of miles. In some areas, it may take patients hours to drive to Performing Provider facilities. Therefore, a mobile clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively.
    - iv. Measure: Expand the hours of a primary care clinic, including evening and/or weekend hours
      1. Metric: Increased number of hours at primary care clinic over baseline

Deleted: <#>Related Projects (RHP participants will specify all other category projects this project would feed into):¶
<#>Reduce Readmissions (Cat. 4)¶
<#>Improve Screening Rates (Cat. 4)¶
<#>Improve Care Management and Outcomes (Cat. 4)¶
<#>Expand Medical Homes (Cat. 2)¶
<#>Redesign Primary Care (Cat. 2)¶
<#>Integrate Physical-Behavioral Health Care (Cat. 2)¶
<#>Redesign for Cost Containment (Cat. 2)¶
<#>Other¶

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a. Data Source: Clinic documentation
b. Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients.

v. Measure: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers
   1. Metric: Documentation of completion of all items described by the RHP plan for this measure.
      a. Data Source: Hospital or other Performing Provider report, policy, contract or other documentation

vi. Measure: Implement a nurse triage software system to assist nurses in determining the acuity of patients
   1. Metric: Documentation of vendor agreement
      a. Data Source: Vendor agreement

vii. Measure: Establish a nurse advice line and/or primary care patient appointment unit
   1. Metric: Performing Provider administrative reports

viii. Measure: Develop automated tracking system for measuring time to next available offered appointment at Performing Provider primary care medical homes for non-urgent needs
   1. Metric: Performing Provider administrative records from patient scheduling system

ix. Measure: Develop and implement a plan for proactive management of adult medicine patient panels through a new Office of Panel Management, such that same-store panel capacity is increased and optimized going forward. This intervention will reopen and optimize use of available adult medicine panel capacity (must include at least one metric):
   1. Metric: Documentation of Office of Panel Management plan, staff assignments, policies and procedures. Documentation of the panel status (open/closed) and panel capacity at points in time.
   2. Metric: Documentation of panel management dynamics (counts of additions, deletions, and total paneled patients) and results of initial panel "cleaning".

x. Measure: Expand episodic care capacity at primary care clinics.

- **Improvement Measures:**

i. Measure: Patient access to primary care by reducing days to third next-available appointment
   a. Metric: Third Next-Available Appointment
      i. The length of time in calendar days between the day a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be seven calendar days (lower is better), but depending on the Performing Provider's starting point, that may not be possible within four years.
      ii. Data Source: Practice management or scheduling systems
      iii. Rationale/Evidence: This measure is an industry standard of patients' access to care. For example, the IHI definition white paper on whole system measures cites this metric.

ii. Measure: Increase primary care clinic volume
   a. Metric: Number of visits, encounters or size of patient panels over baseline

i. Data Source: Registry, EHR, claims or other Performing Provider source
ii. Rationale/Evidence: This measures the increased volume.

iii. Measure: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within X calendar days of request

iv. Measure: Achieve a call abandonment rate for the nurse advice line and patient scheduling unit
   a. Metric: Automated data on call abandonment rate

2. Increase Training of Primary Care Workforce

- **Project Goal:** Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The new primary care workforce will also be trained to operate in patient-centered medical homes. A greater focus on primary care will be crucial to the success of an integrated health care system. Furthermore, in order to effectively operate in a medical home model, there is a need for residency and training programs to expand the capabilities of primary care providers and other staff to effectively provide team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce members will be even more important. In summary, the goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage and to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, community health workers/promotoras) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.

- **Project Options:**
  - 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, and/or quality/performance improvement
  - Increase the number of primary care residents (i.e., physicians, nurse practitioners, physician assistants and other clinicians/staff, such as health coaches and community health workers/*promotoras*)
  - Increase the number of residency/training program faculty/staff to support an expanded, more updated program
  - Increase the number of residents/trainees *choosing* primary care as a career
  - Establish/expand primary care training programs

- Key Measures:

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Deleted: <#>Related Projects:¶
<#>Reduce Readmissions (Cat. 4)¶
<#>Improve Screening Rates (Cat. 3)¶
<#>Improve Diabetes Care Management and Outcomes (Cat. 4)¶
<#>Improve Chronic Care Management and Outcomes (Cat. 4)¶
<#>Expand Medical Homes (Cat. 2)¶
<#>Redesign Primary Care (Cat. 2)¶
<#>Expand Primary Care Capacity (Cat. 1)¶
<#>Other¶

- **Process Measures:**
  i. Measure: Expand primary care training (must include at least one of the following metrics):
     a. Metric: Expand the primary care residency, mid-level provider (physician assistants and nurse practitioners), and/or other clinician/staff (e.g., health coaches, community health workers/promotoras) training programs and/or rotations
        i. Documentation of applications and agreements to expand training programs
        ii. Data Source: Training program documentation
        iii. Rationale/Evidence: Increasing primary care training may help address the primary care workforce shortage.
     b. Metric: Hire additional precepting primary care faculty members
        i. Number of additional training faculty/staff members
        ii. Data Source: HR documents, faculty lists, or other documentation
        iii. Rationale/Evidence: More faculty is needed to expand training programs.
  ii. Measure: Expand positive primary care exposure for residents/trainees (must include at least one of the following metrics):
     a. Metric: Develop mentoring program with primary care faculty and new trainees
        i. Documentation of program
        ii. Data Source: Mentoring program curriculum and/or program participant list
        iii. Rationale/Evidence: Mentoring programs have been found to foster primary care trainees' interest in pursuing primary care careers.
     b. Metric: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels
        i. Documentation of program
        ii. Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee
        iii. Rationale/Evidence: Training programs in primary care should reflect the evolving primary care delivery models.
     c. Metric: Include trainees/rotations in quality improvement projects
        i. Documentation of program
        ii. Data Source: Curriculum and/or quality improvement project documentation/data
        iii. Rationale/Evidence: Including primary care trainees in quality improvement has been linked to trainee satisfaction with primary care.
  iii. Measure: Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement
     a. Metric: Documentation of curricular content in residency program training manuals
  iv. Measure: Implement loan repayment program for primary care providers
     a. Metric: Documentation of program
        i. Data Source: Program materials
        ii. Rationale/Evidence: Loan repayment programs can help to make primary care more attractive.

v. Measure: Create a primary care career pipeline program for secondary school students (specifications to be provided in the RHP plan)
vi. Measure: Establish/expand a faculty development program
    a. Metric: Enrollment of faculty staff into primary care education and training program
        i. Data Source: Program documents
vii. Measure: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites
    a. Metric: Clinical teaching tool
        i. Submission of teaching tools
viii. Measure: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents
    a. Metric: Documentation of ACGME approval for residency position expansion

- **Improvement Measures:**

i. Measure: Increase primary care training and/or rotations
    a. Metric: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline. Trainees may include physicians, mid-level providers (physician assistants and nurse practitioners), and/or other clinicians/staff (e.g., health coaches, community health workers/promotoras).
        - Data Source: Documented enrollment by class by year by primary care training program
        - Rationale/Evidence: As the goal is to increase the primary care workforce to better meet the need for primary care in the health care system by increasing training of the primary care workforce in Texas, the metric is a straightforward measurement of increased training.
    b. Metric: Increase the number or primary care trainees rotating at the Performing Provider's facilities
        - Data Source: Student/trainee rotation schedule
    c. Metric: Increase the number or percent of culturally-competent trainees eligible for existing Texas residency programs
    d. Metric: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline or by absolute number
ii. Measure: Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities
    a. Metric: Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline
        - Data Source: Documentation, such as HR documents compared to class lists
        - Rationale/Evidence: A measure of the success of the training program is how many graduates are choosing to practice primary care at the Performing Provider's facilities.
iii. Measure: Increase the number/proportion of primary care residency/trainee graduates choosing primary care as a career
    a. Metric: Number of primary care residency/trainee graduates choosing primary care as a career

- Numerator: Number of class year residency/trainee graduates choosing primary care as a career
- Denominator: Number of class year residency/trainee graduates
- Data Source: Program documentation
- Rationale/Evidence: Measures success of process measures.

iv. Measure: Increase the number of faculty staff completing educational courses
   a. Metric: Number of staff completing courses

v. Measure: Increase primary care training in Continuity Clinics,[2] which may be in diverse, low-income, community-based settings, (must include at least one of the following metrics):
   a. Metric: Add scheduled Continuity Clinic sessions
      - Data Source: Number of trainee office visits, such as from disease registry, EHR, claims data or other reports
      - Rationale/Evidence: Residents/trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients.
   b. Metric: Assign a Continuity Clinic patient panel to primary care residents
      - Data Source: Patient panel, registry or EHR
      - Rationale/Evidence: Residents/trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients.
   c. Metric: Increase residents' patient clinic rosters

3. Implement and Utilize Disease Management Registry Functionality

- Project Goal: Implement infrastructure that supports patient population health, panel management, and coordination of care.

- Project Options:
  - Implement and utilize disease management registry functionalities
  - Enter patient data into the registry

- Key Measures:
  - **Process Measures:**

i. Measure: Review current registry capability and assess future needs
   a. Metric: Documentation of review of current registry capability and assessment of future registry needs

ii. Measure: Develop cross-functional team to evaluate registry program
   a. Metric: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program

iii. Measure: Implement/expand a functional disease management registry
   a. Metric: Registry functionality is available in X% of the Performing Provider's sites and/or for an expanded number of targeted diseases or clinical conditions

[2] Per the Accreditation Council for Graduate Medical Education (ACGME), "Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients." For more information, please see http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf.

Deleted: <#>Related Projects:¶
<#>Define the RHP'sPPDPH System Population (Cat. 4)¶
<#>Reduce Readmissions (Cat. 4)¶
<#>Improve Quality (Cat. 4)¶
<#>Reduce Harm from Medical Errors (Cat. 4)¶
<#>Reduce Disparities (Cat. 4)¶
<#>Improve Screening Rates (Cat. 3)¶
<#>Improve Diabetes Care Management and Outcomes (Cat. 3)¶
<#>Improve Chronic Care Management and Outcomes (Cat. 4)¶
<#>Expand Medical Homes (Cat. 2)¶
<#>Expand Chronic Care Management Models (Cat. 2)¶
<#>Conduct Medication Management (Cat. 2)¶
<#>Implement/Expand Care Transitions Programs (Cat. 2)¶
<#>Other¶

Deleted: All internal medicine residents typically have continuity clinics. Categorical residents have it just one afternoon per week (often at the hospital-based primary care clinic). Primary care residents have continuity clinic more often during select months and usually have one continuity clinic at the hospital primary care clinic and another off-site (e.g., community or DPH clinic).

i. Numerator: Number of sites with registry functionality
ii. Denominator: Total number of sites
iii. registry includes total number of targeted diseases or clinical conditions
iv. Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation
v. Rationale/Evidence: Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care. Having the functionality in as many sites as possible will enable care coordination for patients as they access various services throughout a Performing Provider's facilities. Registry use can be targeted to clinical conditions/diseases most pertinent to the patient population (e.g., diabetes, hypertension, chronic heart failure).

iv. Measure: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status
   a. Metric: Registry automated report on file
      i. Data Source: Registry
      ii. Rationale/Evidence: To be meaningful for panel management and potentially for population health purposes, registry functionality should be able to produce reports for groups or populations of patients that identify clinical indicators.
      iii. Additional related components:
         1. Expand registry report services to provide on-demand, operational, and historical capabilities, inclusive of reports to care providers, managers, and executives
         2. Expand registry functionality to include electronic structured documentation and clinical decision support at the point of care

v. Measure: Conduct staff training on populating and using the registry functionality
   a. Metric: Documentation of training programs and list of staff members trained, or other similar documentation
      i. Data Source: HR or training program materials
      ii. Rationale/Evidence: Staff need to be trained on appropriate use of the registry functions in order to optimize its use and efficacy.

vi. Measure: Making patient data in the registry more accurate
   a. Metric: Updating patient data based on clinic visit
      i. Numerator: Number of updated entries
      ii. Denominator: Number of unique patients that are in the registry
      iii. Data Source: Registry data report showing entry date
      iv. Rationale/Evidence: Need accurate data to best measure patient care improvements

vii. Measure: Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases (select at least one metric):
   a. Metric: Documented protocols for the specified conditions and health indicators
      i. Data Source: Protocols

b. Metric: Electronic process in place to correctly identify number or percent of screening tests that require additional follow-up
    i. Data Source: Process or other reporting documentation

viii. Measure: Review future potential registry platforms and select registry platform
    a. Metric: Documentation of review of registry platforms and selection of future registry platform

ix. Measure: Implement cross-functional team to staff registry program
    a. Metric: Documentation of personnel (clinical, IT, administrative) assigned to staff registry program

x. Measure: Plan development of/implement tethered registry to capture patients enrolled in chronic disease management program
    a. Metric: Documentation of plan / completion of implementation

- **Improvement Measures:**

i. Measure: Enter patient data into the registry
    a. Metric: Number/percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition); below are potential specifications:
        i. Numerator: Number of patients in registry
        ii. Denominator: Number of patients assigned to this clinic for routine care (i.e., the clinic is the "medical home")
        iii. Data Source: Registry or EHR
        iv. Rationale/Evidence: Supports work of panel management. Establishes patient population for a medical home. (For measurement purposes, a clinic may remove patients from denominator who, once offered a medical home, choose to continue to receive care at multiple sites).

ii. Measure: Number of patient touches recorded in the registry
    a. Metric: Total number of in-person and virtual (including email and web-based) visits, either absolute or divided by denominator
        i. Numerator: Number of patient touches recorded in the registry
        ii. Denominator: Number of targeted patients in the registry ("targeted" as defined by Performing Provider)

iii. Measure: Spread registry functionality throughout Performing Provider facilities
    a. Metric: Implement disease management registry functionality in X% of the Performing Provider's facility sites providing continuity of care for the defined population
        i. Numerator: Number of sites with registry functionality
        ii. Denominator: Total number of sites

iv. Measure: Generate registry-based reports for each provider/care team for the care delivered outside the office visit, which may include historical and peer comparisons for protocols
    a. Metric: Increase or achieve number or reports sent out to number or percent of primary care providers over the 12-month period.
        i. Data Source: Registry and/or EMR

v. Measure: Increase the number of providers/clinicians/staff using the registry
    a. Metric: Number of staff using the registry
        i. Data Source: Registry report

ii. Rationale/Evidence: The more staff that are using the registry, the more current it will be; therefore it will be more useful to monitor patients' conditions. Providers can also monitor their patients across a delivery system – such as from primary care to the hospital.

4. Enhance Interpretation Services and Culturally Competent Care

- Project Goal: Patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and good outcomes.

- Project Options:
  - Identify language access needs and/or gaps in language access
  - Implement language access policies and procedures
  - Increase training related to language access and/or cultural competency/sensitivity
  - Expand language access

- Key Measures:
  - **Process Measures:**
    i. Measure: Conduct an analysis to determine gaps in language access
       a. Metric: Gap analysis
          i. Report results of analysis
          ii. Data Source: Gap analysis
          iii. Rationale/Evidence: It is important to identify needs in order to address those needs/gaps.
    ii. Measure: Implement language access policies and procedures
       a. Metric: Submission of policies and procedures, for example based on *Straight Talk: Model Hospital Policies & Procedures on Language Access*[3]
          i. Data Source: Performing Provider policies and procedures
    iii. Measure: Expand qualified health care interpretation technology
       a. Metric: Video or audio conferencing interpreter terminals and/or areas/units of the Performing Provider with access to health care interpretation technology, for example:
          i. Number of hospital departments/health system clinics with video or audio conferencing terminals over baseline
          ii. Number of total video or audio conferencing terminals over baseline
    iv. Measure: Upgrade hardware systems to function on a wireless network
    v. Measure: Train/certify additional health care interpreters
       a. Metric: Expand capacity of qualified health care interpretation workforce
          i. Numerator: Number of newly trained/certified interpreters
          ii. Denominator: Total number of trained/certified interpreters
          iii. Data Source: HR workforce training data, program materials
          iv. Rationale/Evidence: It is important to make sure staff are fully trained and have the proper certifications necessary to optimize their performance in order to increase language access
    vi. Measure: Train number or proportion of providers and staff to appropriately utilize health care interpreters (via video, phone or in-person)

Deleted: <#>Related Projects:¶
<#>Reduce Disparities (Cat. 3)¶
<#>All Categories 3-4 Projects/Interventions¶
<#>Expand Medical Homes (Cat. 2)¶
<#>Expand Chronic Care Management Models (Cat. 2)¶
<#>Redesign Primary Care (Cat. 2)¶
<#>Redesign to Improve Patient Experience (Cat. 2)¶
<#>Improve Patient/Caregiver Experience (Cat. 4)¶
<#>Redesign for Cost Containment (Cat. 2)¶
<#>Use Palliative Care Programs (Cat. 2)¶
<#>Conduct Medication Management (Cat. 2)¶
<#>Implement/Expand Care Transitions Programs (Cat. 2)¶
<#>Collect Accurate REAL Data (Cat. 1)¶
<#>Other¶

[3] http://www.diversityrx.org/resources/straight-talk-model-hospital-policies-and-procedures-language-access

a. Metric: Expand language access utilization
    i. Numerator: Number of trained providers/staff
    ii. Denominator: Total number of relevant providers/staff (relevant as defined by Performing Provider)
    iii. Data Source: HR workforce training data, program materials
    iv. Rationale/Evidence: It is important to make sure that providers and staff know when and how to appropriately utilize the qualified health care interpretation services available in order to increase language access.

vii. Measure: Develop program to improve staff cultural competency and awareness
    a. Metric: Number of champions/staff that are designated and trained in a population's culture and unique needs
        i. Data Source: HR workforce training data, program materials
        ii. Rationale/Evidence: Cultural competency and awareness can improve patient-provider/staff communication and help to build trust in order to provide equitable and appropriate health care.

viii. Measure: Generate prescription labels in a patient's primary language with easy-to-understand directions
    a. Metric: Number of prescriptions labels translated
        i. Data Source: Report
        ii. Rationale/Evidence: Translation enables appropriate use of prescriptions, helping to prevent incorrect use of medications, which can result in serious health conditions. See *Medical Care* (June 2009 and JCAHO White Paper[4]).

- **Improvement Measures:**
    i. Measure: Improve language access (must select at least one metric):
        a. Metric: The number of qualified health care interpreter encounters per month,[5] based on one of the reporting months within the prior year
            i. Average number of remote video/voice and/or in-person interpreter encounters recorded per month
            ii. Data Source: Automated report (such as from Health Care Interpreter Network or Video Medical Interpretation and/or other encounter data report)
            iii. Rationale/Evidence: Interpreter encounters per month is the current industry standard for how to measure language access. As a result of high numbers of patients whose primary language is not English, the current provision of interpretation services is not meeting the demand. Provision of interpreter services results in patients asking more questions, having a better understanding of treatment plans, and reporting higher patient satisfaction scores (Ku, *Health Affairs*, 2005).

Deleted: DPH systems know that a

Deleted: Some RHP participants may have estimated the current need, but all know that more encounters are the targeted improvement. There may be other measures seemingly more meaningful, but these measures have not been directly linked to provision of health care interpretation and may instead be the result of that plus multiple environmental factors.

[4] http://www.languageline.com/main/files/wp_joint_commission_022211.pdf

[5] "Qualified health care interpreter" is defined as one who has: 1) been trained in healthcare interpreting; 2) adheres to the professional code of ethics and protocols of healthcare interpreters; 3) is knowledgeable about medical terminology; and, 4) can accurately and completely render communication from one language to another. This definition can be found in the JCAHO stansards for interpreters; which, recommends hospital policies and procedures to access interpreters that reflect a commitment to language access, including lists of procedures requiring health care interpretation, a definition of qualified health care interpreter, and maximum wait times for the interpretation encounter. Please see Texas Association of Healthcare Interpreters and Translators.

Deleted: California Health Care Safety Net Institute's *Straight Talk*

Deleted: http://www.safetynetinstitute.org/content/Upload/AssetMgmt/Site/Publications/documents/StraightTalkFinal.pdf

b. Metric: The number of remote video/voice and/or in-person interpreter minutes recorded

ii. Measure: Increase number or percent visits by Limited English Proficient patients that are facilitated by qualified health care interpreters
   a. Metric: Expand qualified health care interpretation workforce
      i. Numerator: The number of visits by Limited English Proficient patients that are facilitated by qualified health care interpreters
      ii. Denominator: Total number of visits by Limited English Proficient patients
      iii. Data Source: TBD by Performing Provider
      iv. Rationale/Evidence: The metric is one way to potentially measure whether demand and supply are aligned, allowing adjustments to be made so that language access is increased.

iii. Measure: Improve Limited English Proficient patients' satisfaction with care and interpreter services
   a. Metric: Percent change in patient satisfaction scores over baseline
      i. Data Source: Results of patient satisfaction survey

iv. Measure: Reduce wait time for interpretation encounters
   a. Metric: The percentage of encounters in which the patient wait time for an interpreter is 15 minutes or less, as specified in *Speaking Together, National Quality Forum or similar* measures,[6] or Average wait time for interpretation encounter, as measured by *Straight Talk: Model Hospital Policies & Procedures on Language Access, National Quality Forum or simlar.*
      i. Data Source: Interpreter services documentation

5. Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

- Project Goal: Develop the ability to and collect accurate patient demographic data in a structured format so that it may be stratified by quality/clinical data in order to identify health care process and clinical outcomes disparities.

- Project Options:
  - Implement a system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify potential health disparities and develop strategies to ensure equitable health outcomes
  - Collect accurate data on race, ethnicity, and language at the point of care
  - Analyze and report on quality outcomes by REAL data categories to identify potential areas of disparities
  - Develop improvement plans to address key factors contributing to the disparities
  - Target and improve identified health outcome disparities
  - Reduce disparities for target patient populations measured through improved rates of preventive care, patient experience, and/or health outcomes

- Key Measures:
  - **Process Measures:**
    i. Measure: Develop REAL data template and/or integrate it into data warehouse, electronic medical record (EMR), and/or registries
       a. Metric: Develop REAL data template

Deleted: <#>Related Projects:¶
<#>Reduce Disparities (Cat. 3)¶
<#>All Categories 3-4 Projects/Interventions¶
<#>Redesign to Improve Patient Experience (Cat. 2)¶
<#>Improve Patient/Caregiver Experience (Cat. 4)¶
<#>Other¶

[6] http://www.rwjf.org/qualityequality/product.jsp?id=29660 or NQF #1828 L3: Patient wait time to receive interpreter services

i. Print screen, report, printout or another source of documentation showing capability to integrate REAL data
ii. Data Source: REAL database, data warehouse, EMR or registry

ii. Rationale/Evidence: The need to collect REAL data is a widely-recognized best practice in the U.S. health care system (e.g., The Joint Commission, the Institute of Medicine, and others).

iii. Measure: Modify registration screens in order to increase the collection of consistent, valid and reliable data
  a. Metric: Adequate registration screens in place
    i. Submission of registration print-screen
    ii. Data Source: Patient registration system
    iii. Rationale/Evidence: Patient registration is the primary point of entry of patient REAL data.

iv. Measure: Train staff on the collection of consistent, valid and reliable data
  a. Metric: Number or proportion of staff trained
    i. Number or percent of staff trained over baseline
    ii. Data Source: HR workforce training data
    iii. Rationale/Evidence: Staff training is crucial to overcome discomfort at collecting REAL data[7]

v. Measure: Develop and implement an organizational process to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify potential health disparities and develop strategies to ensure equitable health outcomes / Implement standardized policies and procedures to ensure the consistent and accurate collection of data
  a. Metric: Description of elements of the system
    i. Documentation of system/processes being implemented
    ii. Data Source: Policies, procedures, or other similar sources
    iii. Rationale/Evidence: In order to stratify quality and safety measures by REAL data, an organization first needs to establish processes to routinely conduct such review.

vi. Measure: Establish REAL sources of accurate point of care data beginning with current Electronic Medical Record as baseline

vii. Measure: Develop a plan to propagate, establish, and document standard REAL data in all relevant patient care systems participating in enterprise standard registration approach.

- **Improvement Measures:**
  i. Measure: Collect accurate REAL data fields as structured data
    a. Metric: The number or percent of patients registered with the Performing Provider
      i. Numerator: Number of unique patients registered with designated REAL data fields
      ii. Denominator: Number of total unique patients registered
      iii. Data Source: Registry, electronic health record, or other registration system
      iv. Rationale/Evidence: The capacity to stratify quality data by REAL data is foundational to being able to identify, address and eliminate health care disparities.

Deleted: Some extent of REAL data collection is included in both the EHR meaningful use and Affordable Care Act programs.

Deleted: DPH system hospitals are at the forefront of entering REAL structure data to be utilized to improve equity and quality of health care, and multiple DPH systems have begun the process of utilizing this approach.

[7] See, for example, HRET Disparities Toolkit, http://www.hretdisparities.org

ii. Measure: Analyze and report on quality outcomes by REAL data categories to identify potential areas of disparities, (e.g., such as utilization of preventive care, improving patient experience and/or various health outcomes)
    a. Metric: REAL data analysis
        i. Documentation of REAL data analysis
        ii. Data Source: Data warehouse, EMR or registry
        iii. Rationale/Evidence: Once accurate REAL data are collected on patients, they must be utilized for quality improvement purposes.[8] All Performing Providers choosing this project will have this as a target goal, but depending on starting point, it may not be possible to do this within four years.

iii. Measure: Develop improvement plans to address key factors contributing to the disparities
    a. Metric: Identification of health care disparities and plans to address those that are targeted/prioritized
        i. Number of identified disparities and documentation of plans
        ii. Data Source: REAL database, data warehouse, EMR or registry
        iii. Rationale/Evidence: The purpose of identifying disparities is to ultimately eliminate them through effective quality improvement efforts. All Performing Providers choosing this project will have this as a target goal, but depending on starting point, it may not be possible to do this within four years.

6. Enhance Urgent Medical Advice

- Project Goal: Provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the ED can be reduced.

- Project Options:
    - 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.
    - 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.

- Key Measures:
    - **Process Measures:**
        i. Measure: Establish baseline and metrics
            a. Metric: TBD by Performing Providers
        ii. Measure: Establish clinical protocols
            a. Metric: Submission of complete protocols
            b. Rationale/Evidence: The nurse advice line would use the clinical protocols
        iii. Measure: Train nurses on clinical protocols
            a. Metric: Number of nurses trained
        iv. Measure: Expand nurse advice line
            a. Metric: Nurse advice line
                i. Numerator: Number of nurses staffing nurse advice line per shift

Deleted: <#>Related Projects:¶
<#>Improve Quality (Cat. 4)¶
<#>Redesign to Improve Patient Experience (Cat. 2)¶
<#>Improve Patient/Caregiver Experience (Cat. 4)¶
<#>Redesign for Cost Containment (Cat. 2)¶
<#>Expand Medical Homes (Cat. 2)¶
<#>Other¶

[8] See, for example, Disparities Solutions Center's Improving Quality and Achieving Equity: A Guide for Hospital Leaders, http://www2.massgeneral.org/disparitiessolutions/guide.html

ii. Denominator: Number of patient calls per shift
iii. Data Source: Documentation of nurse advice line staffing levels.
iv. Rationale/Evidence: Patients will experience expanded access to medical advice and direction to the appropriate level of care as a result of a higher ratio of nurses to patient calls.

v. Measure: Expand access to nurse advice line
   a. Metric: Nurse advice line
      i. Number of enrolled patients who place calls to a nurse advice line
      ii. Data Source: Nurse advice line call center reports
      iii. Rational/Evidence: Patients will experience expanded access to medical advice and direction to appropriate care for perceived urgent medical problems as a result of being able to call a nurse 24 hours per day.

vi. Measure: Establish nurse advice line
   a. Metric: Nurse advice line
      i. Number of nurses designated to staff a nurse advice line
      ii. Data Source: HR documents or other documentation demonstrating employed and/or contracted nurses to staff a nurse advice line.
      iii. Rational/Evidence: Patients will experience expanded access to medical advice and direction to appropriate care for perceived urgent medical problems as a result of being able to call a nurse 24 hours per day.

vii. Measure: Inform and educate patients on the nurse advice line
   a. Metric: Number or percent of targeted patients informed/educated
      i. Numerator: Number of targeted patients informed/educated
      ii. Denominator: Number of targeted patients (targeted as defined by Performing Provider)
      iii. Data Source: Documentation in patient's paper or electronic medical record that patient was contacted and received information about accessing the nurse advice line and education about how to use the nurse advice line
      iv. Rationale/Evidence: Patients who are informed on how to access and utilize a nurse advice line are less likely to seek care for non-emergent conditions in the Emergency Department.

viii. Measure: Develop/distribute a patient-focused educational newsletter with proactive health information and reminders based on nurse advice line data/generated report identifying common areas addressed by the nurse advice line
   a. Metric: Number of newsletters sent to patients
      i. Data Source: Mailer vendor invoice
      ii. Rationale/Evidence: The nurse advice line can collect important data that may be representative of the types of concerns of the larger, general patient population. By monitoring the types of health care needs addressed through the nurse advice line, broader trends can be identified. Based on that, proactive health care guidance (e.g., when to get a screening test/immunization) can be disseminated to the larger patient population. In essence, this shares the learnings from the nurse advice line and disseminates preventive and other health care guidance to the broader patient population.

- **Improvement Measures:**
  i. Measure: Increase in the number of patients that accessed the nurse advice line

a. Metric: Utilization of nurse advice line
    i. Numerator: Number or percent of targeted patients that access the nurse advice line
    ii. Denominator: Targeted patients (targeted as defined by DPH system)
    iii. Data Source: TBD by Performing Provider but could include Call Center phone and encounter records and appointment scheduling software records
    iv. Rationale/Evidence: Targeted patients that access and utilize a nurse advice line are less likely to seek care for non-emergent conditions in the Emergency Department.

ii. Measure: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice and appointment line when needed
    a. Metric: Number of urgent medical appointments scheduled via the nurse advice line
        i. Numerator: Number of patients in defined population who were scheduled for an urgent medical appointment via the nurse advice line
        ii. Denominator: Total number of patients in defined population (defined by Performing Provider)
        iii. Data Source: TBD by Performing Provider but could include Call Center phone and encounter records and appointment scheduling software records
        iv. Rationale/Evidence: Patients in defined population who utilize the nurse advice line and were given an urgent medical appointment when needed are less likely to seek non-emergency care in the Emergency Department.

iii. Measure: Increase the number of patients that call the nurse advice line with intent to go to the ED for non-emergent conditions who are redirected to non-ED resources
    a. Metric: Better utilization of health care resources
        i. Numerator: Number of targeted patients that accessed the nurse advice line who reported intent to go to the ED, but were redirected to non-ED resources
        ii. Denominator: Total number of targeted patients that accessed the nurse advice line who reported intent to go to the ED
        iii. Data Source: TBD by Performing Provider, but could include Call Center phone and encounter records, appointment scheduling software records and Emergency Department medical records.
        iv. Rationale/Evidence: Patients that access the nurse advice line who reported intent to go to the Emergency Department are being directed to appropriate medical resources.

iv. Measure: Increase patient satisfaction
    a. Metric: Increase surveyed patients who believed the advice provided was appropriate
        i. Numerator: Number of surveyed patients who accessed the nurse advice line and reported finding it helpful
        ii. Denominator: Total number of surveyed/respondents who accessed the nurse advice line
        iii. Data Source: Survey Tool Results

iv. Rationale/Evidence: Patients who report they believed the advice they received was appropriate are more likely to not seek care in the Emergency Department for non-emergent conditions in the future.

7. Introduce, Expand, or Enhance Telemedicine/Telehealth

- Project Goal: Provide electronic health care services to increase patient access to health care.

- Project Options:
  - Expand/establish telemedicine/telehealth program to help fill significant gaps in services

- Key Measures: WILL ADD PROCESS AND IMPROVEMENT MEASURES FOR TELEHEALTH
  - **Process Measures:**
    i. Measure: Establish telemedicine program for selected medical service line(s)
       a. Metric: Telemedicine program for selected medical service line(s)
          i. Numerator: Number of telemedicine consults available for selected medical service lines
          ii. Denominator: Number of medical service lines
          iii. Data Source: Appointment scheduling software records
          iv. Rationale/Evidence: Establishing telemedicine consults for selected medical service lines expands access to clinicians.
    ii. Measure: Expand telemedicine program for selected medical service line(s)
       a. Metric: Telemedicine program for selected medical service line(s)
          i. Numerator: Number of telemedicine consults available for selected medical service lines
          ii. Denominator: Number of medical service lines
          iii. Data Source: Appointment scheduling software records
          iv. Rationale/Evidence: Establishing telemedicine consults for selected medical service lines expands access to clinicians.
    iii. Measure: Expand telemedicine program to additional clinics/service lines
       a. Metric: Telemedicine program to clinics
          i. Numerator: Number of clinics with telemedicine
          ii. Denominator: Number of clinics
          iii. Data Source: Appointment scheduling software records
          iv. Rationale/Evidence: Expanding to additional clinics allows increased access.
    iv. Measure: Conduct needs assessment to identify specialties most in need of telemedicine
       a. Metric: Needs assessment
          i. Submission of completed needs assessment
          ii. Data Source: Needs assessment
          iii. Rationale/Evidence: It is important to expand telemedicine to the most impacted areas in order to have optimal affect.

  - **Improvement Measures:**
    i. Measure: Increase number of e-consultations
       a. Metric: Electronic consultations
          i. Numerator: Number of patients referred to medical specialties electronically that have their referral resolved without being scheduled for an in-person visit

Deleted: <#>Related Projects:¶
<#>Redesign to Improve Patient Experience (Cat. 2)¶
<#>Improve Patient/Caregiver Experience (Cat. 4)¶
<#>Redesign for Cost Containment (Cat. 2)¶
<#>Increase Specialty Care Access/Redesign Referral Process (Cat. 2)¶
<#>Other¶

ii. Denominator: Number of patients referred to medical specialties electronically
iii. Data Source: Patient records from electronic referral processing system
iv. Rationale/Evidence: Increased e-consultations will result in the patient's issue being resolved more frequently without need for a face-to-face visit with the specialist.

ii. Measure: Reduce wait times in high-impact specialty for consult for patient's condition
a. Metric: Number of days until first available time for review and consult on patient's condition
i. Data Source: Appointment scheduling software and or electronic referral management software
ii. Rationale/Evidence: Patients are more likely to receive appropriate care when the wait time for review and consult of the condition for which they were referred is shortened.

8. Enhance Coding and Documentation for Quality Data (to create a more robust administrative data set of patient safety and quality codes to use for performance improvement)

- Project Goal: Improve coding and documentation of clinical data so that it reflects a more accurate and specialized data set that can be stratified by quality indicators in order to better identify opportunities for quality improvement.

- Potential Project Elements:
  - Conduct data collection and reporting using ICD-9 codes linked to APR-DRGs
  - Implement HIPAA 5010 transaction sets and convert to ICD-10 codes
  - Implement processes and environmental changes to enhance coding and documentation of diagnoses, procedures, and process and outcome measures

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Deleted: <#>Related Projects:¶ <#>All Categories 3-4 Projects/Interventions¶ <#>Other¶

- Key Measures:
  - **Process Measures:**
    i. Measure: Determine whether current information systems that house ICD codes should be converted or upgraded
    a. Metric: Hospitals and other affected Performing Providers will conduct an impact analysis to identify touch points where ICD codes are used and stored. A structured risk assessment process will be conducted to quantify, order and rank the impact to identify whether information systems will be converted or upgraded.
    i. Submission of analysis
    ii. Data Source: Analysis
    iii. Rationale/Evidence: ICD codes are used in administrative, clinical and financial information systems. Ensuring accurate coding in these systems is critical to maintain hospital operations.
    ii. Measure: Implement HIPAA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions
    a. Metric: Hospitals will convert to the new HIPAA X12 standard that regulates the electronic transmission of specific health care transactions
    i. Documentation of conversion, such as print-out or report
    ii. Data Source: http://www.cms.gov/ICD10/
    iii. Rationale/Evidence: This new standard is a required precursor to mandatory ICD-10 conversion.

iii. Measure: Develop/implement an education plan and/or curriculum for coding staff, clinical documentation specialists, physicians and other staff
   a. Metric: Documentation of the education plan and curriculum

iv. Measure: Train staff on the changes in work flow
   a. Metric: Identify staff to be formally trained on clinical workflow redesign.
      i. Number of trained staff
      ii. Data Source: HR or training program materials
      iii. Rationale/Evidence: Environmental constraints contribute to coding errors.

v. Measure: Implement process to enhance coding and documentation of diagnoses, procedures, and process and outcome measures
   a. Metric: Using a process improvement methodology, identify and rank impact of factors that impact the quality of clinical coding. This may include, but is not limited to, structural characteristics of coding unit, support provided to clinical coders through education, training and resources, and coding quality control mechanisms.
      i. Data Source: Submission of ranked factors
      ii. Rationale/Evidence: Evidence suggests organizational factors affect the quality of hospital clinical coding.

vi. Measure: Modify existing clinical documentation improvement tools for ICD-10
   a. Metric: Documentation of updated tools

vii. Measure: Conduct data collection and reporting using ICD-9 codes linked to APR-DRGs

viii. Measure: Increase utilization of data quality reports to identify data improvement priorities
   a. Metric: Review data reports quarterly and identify at least three data improvement priorities
      i. Data Source: Internal data reports
      ii. Rationale/Evidence: Continuous monitoring will allow hospitals to identify and correct data improvement opportunities.

ix. Measure: Determine a methodology to calculate costs per APR-DRG clinical conditions
   a. Metric: Development, documentation and submission of a methodology to calculate costs per APR-DRG clinical conditions

x. Measure: Designate a project manager for coding/documentation
   a. Metric: Submission of project manager role/position description, or HR documents

xi. Measure: Complete an audit of the clinical documentation improvement program
   a. Metric: Number or percent of records audited to evaluate accuracy of coding in ICD-10
      i. Numerator: Number of records audited
      ii. Denominator: Total records

o **Improvement Measures:**

i. Measure: Implement ICD-10 conversion to be able to communicate with institutions that are able to receive such transactions
   a. Metric: All internal information systems (administrative, financial, and clinical) using ICD-9 codes will either convert to ICD-10 or crosswalk old ICD-9 codes to ICD-10 codes.
      i. Data Source: http://www.cms.gov/ICD10/

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ii. Rationale/Evidence: Conversion to ICD-10 codes is mandated by CMS and will be required for reimbursement

ii. Measure: Implement improvement strategies to ensure accurate coding of patient safety indicators
   a. Metric: Reduce coding errors
      i. Percent change in coding errors over baseline
      ii. Data Source: Random chart audits or other coding quality control mechanisms
      iii. Rationale/Evidence: Accurate coding has important patient care delivery, clinical and reimbursement/financial impacts.

iii. Measure: Use accurate coding to identify high utilizers of services or high risk patients and then develop and implement clinical pathways to more effectively deliver needed care.
   a. Metric: Demonstrate utilization of clinical pathways or document clinical pathway in policy and procedure manual as a metric.
      i. Data Source: Random chart audits or other coding quality control mechanisms
      ii. Rationale/Evidence: Accurate coding can reveal patterns in utilization that can then help drive improvement efforts that have direct impact on delivery of patient care, clinical outcomes, and reimbursement/financial benefits. Accurate coding has important patient care delivery, clinical and reimbursement/financial impacts.

9. Expand Specialty Care Capacity

- Project Goal: To increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

- Project Options:
  - Identify high impact/most impacted specialty services[9] and gaps in care and coordination
  - Expand high impact specialty care capacity in most impacted medical specialties
  - Increase the number of residents/trainees choosing targeted shortage specialties
  - Establish or expand initiatives to increase the availability of targeted specialty providers
  - Develop workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)
  - Enhance service availability (hours, clinic locations, etc.)

- Key Measures:
  - **Process Measures:**
    i. Measure: Assess specialty clinic capacity, productivity, and/or care models
       a. Metric: Performing Provider's administrative records
    ii. Measure: Collect baseline data for wait times, backlog, and/or return appointments in specialties
       a. Metric: Establish baseline for performance indicators
          i. Numerator: TBD by the Performing Provider
          ii. Denominator: TBD by the Performing Provider
          iii. Data Source: TBD by the Performing Provider
          iv. Rationale/Evidence: TBD by the Performing Provider

[9] Such as: Cardiology, Gastroenterology, Orthopedics, Endocrinology, Psychiatry, and Dermatology

Deleted: 9. Develop Risk Stratification Capabilities/Functionalities ¶
<#>Project Goal: To develop the capability to target high-risk patients by collecting accurate patient data and stratifying by health risk indicators.¶
¶
<#>Potential Project Elements:¶
<#>Develop criteria to better identify those patients that would benefit from disease management and other special programs¶
<#>Conduct risk stratification for patients with the targeted chronic conditions¶
<#>Apply the risk stratification methodology, produce risk scores for the patients, and assign them to the appropriate medical home and disease management program¶
¶
<#>Other Category Projects This Project Can Feed Into:¶
<#>Reduce Readmissions (Cat. 3)¶
<#>Improve Quality (Cat. 3)¶
<#>Reduce Harm from Medical Errors (Cat. 3)¶
<#>Prevent Ventilator Associated Pneumonia (VAP) Infection (Cat. 3)¶
<#>Improve Diabetes Care Management and Outcomes (Cat. 3)¶
<#>Improve Chronic Care Management and Outcomes (Cat. 3)¶
<#>Expand Chronic Care Management Models (Cat. 2)¶
<#>Redesign for Cost Containment (Cat. 2)¶
<#>Implement/Expand Care Transitions Programs (Cat. 2)¶
<#>Other¶
¶
<#>Key Measures:¶ … [1]

Deleted: 10. Expand Capacity to Provide Specialty Care Access in the Primary Care Setting¶
<#>Project Goal: Provide high-demand specialty services within the primary care/medical home setting so that patients can receive some specialty care services concurrent with routine appointments in order to increase patient access to specialty care by avoiding the need for separate specialist visits where possible.¶
¶
<#>Potential Project Elements:¶
<#>Provide training to primary care providers to expand their capacity to provide select, basic specialty care within the primary care setting¶ … [2]

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Deleted: <#>Related Projects:¶
<#>Improve Quality (Cat. 4)¶
<#>Increase Specialty Care Access/Redesign Referral Process (Cat. 2)¶
<#>Redesign to Improve Patient Experience (Cat. 2)¶
<#>Improve Patient/Caregiver Experience (Cat. 4)¶
<#>Other¶

iii. Measure: Expand the ambulatory care medical specialties referral management department and related functions
   a. Metric: System/personnel in place to manage referrals into medical specialties
      i. Numerator: System components/personnel
      ii. Denominator: Monthly/annual volume of referrals into medical specialties
      iii. Data Source: Number of FTEs/Written description for process of managing referrals into medical specialties
      iv. Rationale/Evidence: A robust referral management department or clinic function can ensure that referrals are processed, reviewed and the patient's clinical issue addressed in a timely manner.

iv. Measure: Train primary care providers, specialists and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties
   a. Metric: Training of staff and providers on referral guidelines, process and technology
      i. Numerator: Number of staff and providers trained and documentation of training materials
      ii. Denominator: Total number of staff and providers working in primary care and medical specialty clinics
      iii. Data Source: Curriculum for training
      iv. Rationale/Evidence: Training all staff and providers working in primary care and in medical specialty clinics on referral guidelines, process, and technology creates the capacity to consistently and uniformly manage all referrals into medical specialties.

v. Measure: Launch a specialty care clinic (e.g., pain management clinic)
   a. Metric: Establish/expand specialty care
      i. Documentation of new/expanded specialty care clinic

vi. Measure: Conduct a specialty care gap analysis based on community need

vii. Measure: Implement a specialty care access plan

viii. Measure: Complete planning and installation of new specialty systems (e.g., imaging systems)

ix. Measure: Establish specialty care guidelines for the high impact/most impacted medical specialties.
   a. Document guidelines and distribution of guidelines.

x. Measure: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
   a. Metric: Reports on file

xi. Measure: Expand targeted specialty care (TSC) training (must include at least one of the following metrics):
   a. Metric: Expand the TSC residency, mid-level provider (physician assistants and nurse practitioners), and/or other specialized clinician/staff training programs and/or rotations
      i. Documentation of applications and agreements to expand training programs
      ii. Data Source: Training program documentation
      iii. Rationale/Evidence: Increasing TSC training may help improve access to targeted specialty services.
   b. Metric: Hire additional precepting TSC faculty members
      i. Number of additional training faculty/staff members
      ii. Data Source: HR documents, faculty lists, or other documentation

iii. Rationale/Evidence: More faculty is needed to expand training programs.

xii. Measure: Implement loan repayment program for TSC providers
   a. Metric: Documentation of program
      i. Data Source: Program materials
      ii. Rationale/Evidence: Loan repayment programs can help to make TSC more attractive.

xiii. Measure: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents
   a. Metric: Documentation of ACGME approval for residency position expansion

xiv. Measure: Implement the re-design of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity.
   a. Metric: Number of medical specialty clinics that have completed clinic redesign.
      i. Numerator: Average cycle time of appointments in medical specialty clinics that have undergone re-design.
      ii. Denominator: Overall average cycle time of appointments in all medical specialty clinics.
      iii. Data Source: Specialty clinic appointment tracking system.
      iv. Rationale/Evidence: Re-designing medical specialty clinics in order to shorten appointment cycle time and maximize provider productivity allows the most efficient utilization of specialty provider resources.

xv. Measure: Conduct specialty care gap assessment
   a. Metric: Gap assessment
      i. Submission of completed assessment
      ii. Data Source: Assessment
      iii. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access

xvi. Measure: Analyze occurrence of unnecessary specialty clinic follow-up appointments
   a. Metric: Number of unnecessary specialty clinic follow-up appointments
   b. Data Source: Chart review with protocol for determining unnecessary follow up visits

- **Improvement Measures:**

i. Measure: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties
   a. Metric: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties
      i. Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties
      ii. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of specialist providers in targeted specialties at baseline
      iii. Data Source: HR documents or other documentation demonstrating employed/contracted specialists

iv. Rationale/Evidence: Increased number of specialists to meet demand and referral demand for in-person visits and procedures will allow patients to receive more timely services.

ii. Measure: Increase the number of available specialty appointments by XX for the most impacted specialty clinics
   a. Metric: Documentation of increase over baseline

iii. Measure: Increase the number of referrals of targeted patients to the specialty care clinic
   a. Metric: Achieve target of referrals of targeted patients
      i. Data Source: Registry and/or paper documentation as designated by Performing Provider
      ii. Rationale/Evidence: Targeted patients are at high-risk of admissions and/or readmissions, and getting the patients to the specialty care clinics can help manage their conditions and therefore avoid unnecessary ED utilization, hospitalizations or readmissions.

iv. Measure: Reduce the number of specialty clinics with waiting times for next routine appointment
   a. Metric: Next routine appointment of more than X calendar days and/or to no more than X of X specialty clinics or specialty practices
   b. Data Source: Performing Provider appointment scheduling system

v. Measure: Increase TSC training and/or rotations (must select one of the following metric):
   a. Metric: Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline. Trainees may include physicians, mid-level providers (physician assistants and nurse practitioners), and/or other specialized clinicians/staff .
      i. Data Source: Documented enrollment by class by year by TSC training program
      ii. Rationale/Evidence: As the goal is to increase the TSC workforce to better meet the need for TSC in the health care system by increasing training of the TSC workforce in Texas, the metric is a straightforward measurement of increased training.
   b. Metric: Increase the number of TSC trainees rotating at the Performing Provider's facilities
      i. Data Source: Student/trainee rotation schedule
   c. Metric: Increase the number or percent of culturally-competent trainees eligible for existing Texas residency programs
   d. Metric: Increase the number of TSC care residents and/or trainees, as measured by percent change of class size over baseline or by absolute number

vi. Measure: Recruit/hire more trainees/graduates to TSC positions in the Performing Provider's facilities or practices
   a. Metric: Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities or practices over baseline
      i. Data Source: Documentation, such as HR documents compared to class lists
      ii. Rationale/Evidence: A measure of the success of the training program is how many graduates are choosing to practice in TSC at the Performing Provider's facilities.

10. Enhance Performance Improvement and Reporting Capacity

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

- Project Goal: To expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.

- Project Options:
  - Enhance improvement capacity within people
  - Enhance improvement capacity through technology

- Key Measures:
  - **Process Measures:**
    i. Measure: Establish a performance improvement office to manage data, improvement trajectory and improvement activities across the Performing Provider's delivery system
       a. Metric: Establishment of office
          i. Documentation of establishment of office
          ii. Rationale/Evidence: Having an office responsible for performance improvement will increase organizational capacity to and demonstration organizational commitment to performance improvement activities ongoing.
    ii. Measure: Establish a program for trained experts on process improvements to mentor and train other staff for safety and quality care improvement
       a. Metric: Train the trainer program established
          i. Documentation of training program
          ii. Data Source: HR, training program materials
          iii. Rationale/Evidence: Ongoing training throughout the organization in quality care improvement will increase capacity for quality improvement activities on an ongoing basis.
    iii. Measure: Develop reporting methodologies that will enable continuous quality improvement
       a. Metric: TBD by Performing Provider
          i. Numerator: TBD by Performing Provider
          ii. Denominator: TBD by Performing Provider
          iii. Data Source: Report systems TBD by Performing Provider
          iv. Rationale/Evidence: It is important to put in place meaningful measurements of quality improvement to measure progress and drive continuous improvement.
    iv. Measure: Participate in statewide, regional, public hospital or national clinical database(s) for standardized data sharing
       a. Metric: Collaborative membership
          i. Documentation of collaborative membership
          ii. Data Source: Collaborative membership materials
          iii. Rationale/Evidence: Participating in a collaborative has been shown to drive targeted and concerted quality improvement activities with the support of peers and the program.
    v. Measure: Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues
       a. Metric: Number of learning events
          i. Data Source: Learning events' agendas
          ii. Rationale/Evidence: It is also important to share the learnings of quality improvement efforts – what worked and what did not work.

Deleted: <#>Related Projects:¶
<#>All Categories 1-4 Projects/Interventions ¶
<#>Other¶

vi. Measure: Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data, as well as utilize them for quality improvement
   a. Metric: Patient experience data
      i. Documentation of methodology for patient experience data collecting and reporting
      ii. Data Source: TBD by Performing Provider
      iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions.

vii. Measure: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)
   a. Metric: Number of staff trained
      i. Data Source: HR, training programs
      ii. Rationale/Evidence: It is essential to have in place the resources and brainpower to drive performance improvement work.

o **Improvement Measures:**

i. Measure: Implement quality improvement data systems, collection, and reporting capabilities
   a. Metric: Usable quality improvement data systems
      i. Generation of report
      ii. Data Source: Quality improvement data systems
      iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions.

ii. Measure: Create a quality dashboard or scoreboard to be shared with organizational leadership on a regular basis that includes patient satisfaction measures
   a. Metric: Quality dashboard
      i. Submission of quality dashboard
      ii. Data Source: Quality improvement data systems
      iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions.

Note: Some projects from Category 2, Project 6, likely increasing access and provider capacity, will be moved to Category 1 Project 11 on Expand Behavioral Healthcare Capacity.

12. Increase, Expand, and Enhance Dental Services

- Project Goal: Increase/Enhance Access to Dental Services; including increased provider training. Dental health is a key component of overall health and well-being that also helps avert preventable illnesses and conditions. Limited access to dental services compounds other health issues. Increasing, expanding and enhancing dental services will improve care outcomes including those related to pregnancy, diabetes, and cardiovascular conditions.[10]

- Project Options:

[10] http://www.perio.org/consumer/media/releases.htm#pregnancy

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- Increase provider training, recruitment and retention, including initiative(s) to support access to dental services in underserved markets and areas (dentists, dental hygienists or related).
- Increase and expand services by increasing clinics, clinic hours, using mobile clinics, or other approaches to increase patient access to dental services.

Deleted: <#>Related Projects:¶ <#>Evidence-based health promotion/disease prevention (Cat. 2)¶ <#>Redesign for Cost Containment (Cat. 2)¶ <#>Improve Quality (Cat. 4)¶ <#>Improve Patient flow (Cat. 2) ¶ <#>Enhance/Expand medical homes (Cat. 2)¶

- Key Measures:
  - **Process Measures:**
    - i. Measure: Expand dental care training, (must include at least one of the following metrics):
      - b. Metric: Expand the dental care training programs
        - i. Documentation of applications and agreements to expand training programs
        - ii. Data Source: Training program documentation
        - iii. Rationale/Evidence: Increasing dental care training may help address the dental care workforce shortage.
      - c. Metric: Hire additional dental care faculty members
        - i. Number of additional training faculty/staff members
        - ii. Data Source: HR documents, faculty lists, or other documentation
        - iii. Rationale/Evidence: More faculty is needed to expand training programs.
      - d. Metric: Train trainees in the medical home model, chronic Care Model and/or disease registry use
        - i. Documentation of program
        - ii. Data Source: Curriculum
        - iii. Rationale/Evidence: Training programs for dental care should reflect impact on other health conditions and coordination with medical homes in evolving care delivery models.
      - e. Metric: Include trainees/rotations in quality improvement projects
        - i. Documentation of program
        - ii. Data Source: Curriculum and/or quality improvement project documentation/data
        - iii. Rationale/Evidence: Including dental care trainees in quality improvement will improve quality
    - ii. Measure: Implement loan repayment; recruitment or retention program for dental care providers in underserved markets
      - f. Metric: Documentation of program
        - i. Data Source: Program materials
        - ii. Rationale/Evidence: These programs can help to attract and keep dental services in underserved markets.
    - xi. Measure: Establish additional/expand existing/relocate dental care clinics or space
      1. Metric: Number of additional clinics or expanded hours or space
         a. Documentation of expansion
         b. Data Source: New dental care schedule or other document
         c. Rationale/Evidence: The supply of dental care providers does not meet the demand for services.
    - xii. Measure: Implement/expand a mobile dental health clinic program
      1. Metric: Number of additional clinics or expanded hours or space
         a. Documentation of expansion
         b. Data Source: New dental care schedule or other document

c. Rationale/Evidence: Many RHPs and Performing Providers cover very large counties, including hundreds of miles. In some areas, it may take patients hours to drive to existing dental care sites. Therefore, a mobile clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively.

xiii. Measure: Expand the hours of a dental care clinic or office, including both evening and/or weekend hours

1. Metric: Increased number of hours at dental care clinic or office over baseline
   a. Data Source: Clinic or office hour documentation
   b. Rationale/Evidence: Expanded hours can not only allow for more patients to be seen, but also provides more choice for patients.

- **Improvement Measures:**

i. Measure: Increase dental care training (must select one of the following metrics):

d. Metric: Increase the number of dental care trainees, as measured by percent change of class size over baseline. Trainees may include dentists, dental hygenists, or related staff.
   - Data Source: Documented enrollment by class by year by dental care training program
   - Rationale/Evidence: As the goal is to increase the dental care workforce to better meet the need for dental care in the health care system by increasing training of the dental care workforce in Texas, the metric is a straightforward measurement of increased training.

e. Metric: Increase the number or dental care trainees at the Performing Provider's facilities
   - Data Source: Student/trainee schedule

f. Metric: Increase the number or percent of culturally-competent trainees eligible for existing Texas dental programs

g. Metric: Increase the number of dental care trainees, as measured by percent change of class size over baseline or by absolute number

ii. Measure: Recruit/hire more trainees/graduates to provide services in targeted underserved areas identified by Performing Provider facilities

h. Metric: Percent change in number of graduates/trainees accepting positions in the Performing Provider facilities over baseline
   - Data Source: Documentation, such as HR documents compared to class lists
   - Rationale/Evidence: A measure of the success of the training program is how many graduates provide dental services at underserved sites identified by Performing Provider facilities.

iii. Measure: Patient access to dental care by reducing days to next-available appointment

i. Metric: Next-Available Appointment The length of time in calendar days between the day a patient makes a request for an appointment with an office or clinic and the next available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month.
   - Data Source: Practice management or scheduling systems
   - Rationale/Evidence: This measure is the industry standard for dental care.

iv. Measure: Increase dental care clinic or office volume
    j. Metric: Number of visits, encounters or size of patient panels over baseline
        - Data Source: Clinic or office registry, billing or other Performing Provider source
        - Rationale/Evidence: This measures the increased volume.

v. Measure: Increased volume of dental services provided over baseline.
    k. Metric: Number of preventive visits (e.g., cleanings, initial exams) and number of dental services (fillings, etc.) provided over baseline
        - Data Source: clinic or office documentation of visits or other Performing Provider source
        - Rationale/Evidence: Measuring increase in dental services provided reflects the goal of increased dental services.

13. Expand or Enhance Emergency Medical Transportation Services

- Project Goal: Increase capacity for emergency medical transportation in areas with documented insufficient services. Texas has vast rural areas. Expansion and enhancement of services will improve rural Texas' ability to more quickly and effectively provide critical services and emergency transportation. In addition, transportation between urban providers or between rural and urban providers is critical to ensure patients receive timely care in the appropriate facility for their care needs.

- Project Options:
    - Expand or enhance existing emergency medical transportation capacity with additional vehicles, staff and related infrastructure to address documented shortages.
    - Develop and implement or enhance existing emergency medical transportation systems and/or regional coordination to improve efficiency and timeliness of emergency medical transportation.
    - Develop and enhance transfer systems to reduce times from initial patient intake to location of appropriate care level.

Deleted: Related Projects:¶
<#>Redesign for cost-containment (Cat.2)¶
<#>Quality of Care (Cat. 4)¶

- Key Measures:
    - **Process Measures:**
        i. Measure: Implement transfer guideline.
            a. Metric: Documentation of guideline
                i. Data Source: Performing Provider documentation.
        ii. Measure: Implement infrastructure to facilitate links to regional hospitals, EMS agencies and related entities.
            a. Metric: Documentation of implementation.
                i. Data Source: TBD by Performing Provider
        iii. Measure: Implement functional infrastructure to coordinate hospital transfers between different hospital systems
            a. Metric: Presence of a regional transfer center with fault-tolerant, secure communications links and a minimum threshold of a < X minute mean time to accept a transfer (averaged over a 12-month period) for critical patients.
                i. Data Source: Data from EMS systems.
        iv. Measure: Develop or implement expansion or service enhancement for emergency medical transportation
            a. Metric: Development plan completed or implementation completed.
                i. Data Source: Written development plan and evidence of implementation (vehicles, staffing, and infrastructure improvements documentation).

v. Measure: Develop and implement or enhance existing medical transportation systems and/or regional coordination in rural areas or between rural and urban areas.
    a. Metric: Development plan completed; implementation completed; or enhancement plan developed or implemented.
        i. Data Source: Documentation of plan or implementation.
vi. Measure: Other as determined by the Performing Provider to show evidence of appropriate improvement measure related to emergency medical transportation implementation, expansion, or enhancement.
    a. Metric: TBD by Performing Provider

- **Improvement Measures**

vii. Measure: Transfer time from intake site to final care site.
    a. Metric: Transfer time from intake site to final care site. Decrease the transfer time from intake to location of appropriate level of care by XX% over baseline or to X hours or less. Average transfer time from intake to location of appropriate level of care
    b. Metric: other to be determined by Performing Provider
viii. Measure: Increase participation in regional coordination system.
    a. Metric: Increase of X number of facilities and/agencies participating in transfer center.
        ii. Numerator: Number of acute care hospitals and EMS agencies participating in transfer center
        iii. Denominator: Total number of acute care hospitals and EMS agencies in RHP region
ix. Measure: Demonstrate coordination of transfers with a mean acceptance time of < 15 minutes.
    a. Metric: Increase the number of transfers meeting X target or increase performance on target over baseline by X.
x. Measure: Other as determined by the Performing Provider to show evidence of appropriate improvement measure related to emergency medical transportation implementation, expansion, or enhancement.
    a. Metric: TBD by Performing Provider

Attachment I
Regional Healthcare Partnership (RHP) Planning Protocol

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9. Develop Risk Stratification Capabilities/Functionalities

Project Goal: To develop the capability to target high-risk patients by collecting accurate patient data and stratifying by health risk indicators.

Potential Project Elements:
Develop criteria to better identify those patients that would benefit from disease management and other special programs
Conduct risk stratification for patients with the targeted chronic conditions
Apply the risk stratification methodology, produce risk scores for the patients, and assign them to the appropriate medical home and disease management program

Other Category Projects This Project Can Feed Into:
Reduce Readmissions (Cat. 3)
Improve Quality (Cat. 3)
Reduce Harm from Medical Errors (Cat. 3)
Prevent Ventilator Associated Pneumonia (VAP) Infection (Cat. 3)
Improve Diabetes Care Management and Outcomes (Cat. 3)
Improve Chronic Care Management and Outcomes (Cat. 3)
Expand Chronic Care Management Models (Cat. 2)
Redesign for Cost Containment (Cat. 2)
Implement/Expand Care Transitions Programs (Cat. 2)
Other

Key Measures:
Process Measures:
Measure: Develop adaptive screening tools for patients with targeted conditions/indicator/criteria
Metric:
Numerator: Number of patients detected as having increased risk by tool
Denominator: Total number of targeted patients admitted
Data Source: EHR, trauma registry, ICU database, EHR screening tool database
Rationale/Evidence: Since many of the subject patients have poor access to primary care, the admission may be an indication of overall worsening health, high-risk behavior and/or poorly managed diseases. By employing an adaptive screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible.
Measure: Develop and implement risk stratification to identify patient populations who would benefit from specialized medical homes, disease management programs, remote monitoring, and other special programs
Measure: Develop criteria to better identify those patients that would benefit from disease management and other special programs

Improvement Measures:
Measure: Conduct risk stratification for number or percent of patients with the targeted chronic conditions
Metric:
Numerator: All major trauma victims successfully screened for targeted conditions.
Denominator: All major trauma victim admissions
Data Source: EHR, trauma registry, EHR screening tool results

Rationale/Evidence: Screening and rapid intervention for at-risk conditions for inpatients have not been funded by traditional insurance or safety-net coverage, despite demonstration of improved outcomes and reduction in costs. Since most of the subject patients have poor access to primary care, the trauma admission may be an indication of overall worsening health, high risk behavior and/or poorly managed diseases. By employing an adaptive computer-based screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible.

Measure: Apply the risk stratification methodology, produce risk scores for # or % of patients, and assign them to the appropriate medical home and disease management program

Measure: Using the risk stratification process, order appropriate interventions and make appropriate timely referrals for number or percent of targeted patients with the targeted conditions, such as implementing remote monitoring (telephonic, web or device-based) and appropriate nurse management follow-up of patients with heart failure post inpatient discharge

Metric

Numerator: All major trauma victims successfully screened for targeted conditions and appropriate referred without recividism at UCSD or the San Diego Trauma System hospitals.

Denominator: All major trauma victims successfully screened for targeted conditions and appropriate referred

Data Source: EHR, trauma registries, EHR screening tool results

Rationale/Evidence: Safety-net hospital studies have shown that subsets of underprivileged trauma patients have disproportionate rates of readmission, increased hospital costs and excess morbidity and mortality. These adverse outcomes could be reduced by improved screening and management. By employing an adaptive screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible. Appropriate consultations and referrals will be indicated and ordered via the EHR, where available. In addition, long-term plans for secondary prevention of injury and illness can be coordinated for the patient and family, inpatient specialist provider and consultants and primary care providers, and these plans output to patients primary care EHR, where available.

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10. Expand Capacity to Provide Specialty Care Access in the Primary Care Setting

Project Goal: Provide high-demand specialty services within the primary care/medical home setting so that patients can receive some specialty care services concurrent with routine appointments in order to increase patient access to specialty care by avoiding the need for separate specialist visits where possible.

Potential Project Elements:

- Provide training to primary care providers to expand their capacity to provide select, basic specialty care within the primary care setting
- Have high impact specialists regularly rotate through medical homes for team conferences, team training, and patient consultation/co-management
- Develop clinical management protocols for primary care providers to co-manage patients with specialists
- Develop a process to enable enhanced communication between primary care providers and specialists on a regular basis
- Increase clinic hours for select primary care providers to provide expanded care to selected patient population

Develop a protocol for primary care providers to co-manage patients with clinical pharmacists for select conditions

Related Projects:

Increase Specialty Care Access/Redesign Referral Process (Cat. 2)
Redesign to Improve Patient Experience (Cat. 2)
Improve Patient/Caregiver Experience (Cat. 3)
Redesign for Cost Containment (Cat. 2)
Improve Diabetes Care Management and Outcomes (Cat. 3)
Improve Chronic Care Management and Outcomes (Cat. 3)
Other

Key Measures:

Process Measures:

Measure: Provide training to primary care providers to expand their capacity to provide select, basic specialty care within the primary care setting

Metric: Training of primary care providers in at least one specialty care area

Number of trained primary care providers in the specialty care areas selected

Data Source: HR, training program materials, or curriculum for training in select medical specialties

Rationale/Evidence: Enables an expanded role or expanded/additional clinical expertise for primary care providers.

Measure: Have specialists from most impacted medical specialties regularly rotate through medical homes for team conferences, team training, and patient consultation/co-management

Metric: Specialists consulting on cases with primary care providers in primary care clinic/medical home

Numerator: Number of patient cases jointly reviewed by primary care provider and medical specialist in selected medical specialties

Denominator: Number of adult patients seen at the clinic

Data Source: Paper or electronic log of number of cases presented at monthly conference tracked over time. The number of referrals made over time as tracked in practice management system, EHR, or other documentation as designated by DPH system. Practice management system, EHR, or other documentation as designated by DPH system to provide the number of adult patients seen at clinic. Patient charts or patient note in electronic medical record.

Rationale/Evidence: Primary care providers able to consult with medical specialists on a regular basis refer fewer patients for in-person visits into associated medical specialty clinic. This process could include scheduling a one hour meeting/conference once per month where the primary care provider presents cases to the specialist. The following month, the specialist could do a brief (10-15 minute) presentation/review of the topic brought up in a specific case from the prior month before moving on the case

presentations from the current month. The primary care provider would have to have their cases and specific question prepared ahead of time. This could allow 3-4 cases per month to be "jointly reviewed." And lessons learned could be shared with all—as opposed to 1:1 consultation.

- Measure: Develop clinical management protocols for the most impacted medical specialties jointly created by primary care providers and specialists for the co-management of patients between primary care and targeted medical specialties
  - Metric: Clinical Management Protocols for selected medical specialties
    - Numerator: Clinic Management Protocols for selected medical specialties
    - Denominator: Total number of medical specialties
    - Data Source: Written Clinical Management Protocol
    - Rationale/Evidence: Patients being co-managed by primary care providers and medical specialists according to a jointly created clinical management protocol are more likely to receive care in the most appropriate setting. Also, a health care system which has engaged their primary care and medical specialty providers to create mutually agreed upon parameters for their respective roles is likely to deliver care in the most appropriate setting.
- Measure: Conduct specialty care gap assessment
  - Metric: Gap assessment
    - Submission of completed assessment
    - Data Source: Assessment
    - Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access

Improvement Measures:

- Measure: Number of patients referred for in-person visits into select medical specialty clinic(s)
  - Metric: Referrals from primary care into select medical specialties
    - Numerator: Number of patients with a given diagnosis who are referred for in-person visits/consultations with select medical specialty clinics
    - Denominator: Total number of patients with the given diagnosis
    - Data Source: eReferral management software and appointment scheduling software
    - Rationale/Evidence: Medical specialty resources will be utilized more appropriately resulting in the prioritization of medical specialty care for patients with conditions that require in-person specialty consults and procedures.