PERFORMANCE IMPROVEMENT PLAN

February 2014

I.PURPOSE:

The purpose of Three Lower Counties Community Services Performance Improvement Program is to establish a planned, systematic, organization-wide approach to process design and performance measurement, analysis, and improvement.

II.GOALS:

The goal of TLCCS performance improvement program is to improve the health status of the population served by a process of data collection, monitoring, and evaluation of findings by improving and sustaining the improved performance. TLCCS will establish priorities and specific goals for selected indicators, which will be reviewed annually.

1. Safety-avoiding injuries to patients from the care that is intended to help them;
2. Effectiveness -providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit;
3. Patient Centered-providing care that is respectful of, and responsive to, individual client preferences, needs, and values and ensuring that client values guide all clinical decisions;
4. Timeliness -reducing waits and potentially harmful delays;
5. Efficiency -avoiding waste, including waste of equipment, supplies, ideas and energy;
6. Equitable -providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, sexual orientation, geographic location, and socioeconomic status.

III.OBJECTIVES:

Objectives are measured annually. In projecting future objectives, TLCCS will consider the resources available, patient population, as well as, facilitators and barriers to improving clinical processes, systems, protocols, etc. Progress towards meeting these objectives will be documented in the bi-monthly Performance Improvement meeting minutes.

The Performance Improvement Program at Three Lower Counties Services includes the following:

1. Support TLCCS mission and strategic plan;
2. Systematically plan, monitor performance, analyze current performance, improve and sustain improvements of processes and outcomes of patient care through interdisciplinary teams, clinical service, and peer review;
3. Provide a mechanism for establishing organization wide performance improvement priorities;
4. Address our client populations needs and expectations;
5. Promote interdepartmental and interdisciplinary communication with a scientific approach to problem solving;
6. Facilitate dissemination, discussion and understanding of clinical and management data among staff and providers;
7. Measure the organization's key outcomes, activities, and processes to support safety, improvement, innovation, and learning;
8. Provide a mechanism by which providers and staff are educated in performance improvement principles and processes;

9. Develop an environment that encourages and empowers staff to identify and address issues through the performance improvement process;
10. Create and sustain a patient centered care environment to elicit improved outcomes, empower patient self-management and health literacy for our patient population.
11. Support compliance with Joint Commission accreditation standards, NCQA PCMH standards, and regulatory agency requirements.

IV.SCOPE:

TLCCS Performance Improvement Program consists of the coordination of preventive, acute and chronic care services, which are provided on an outpatient basis **(see P.I. form 1.C)**.

1. Evaluation of all direct client care services as well as indirect services affecting patient health;
2. Evaluation of staff competency ;
3. Patient/Staff/Provider satisfaction surveys;
4. Evaluation of organizational performance, including, but not limited to:

    a. Risk management (to include Safety and Environment of Care, Infection Control and Adverse Incident Reviews)
    b. Utilization management
    c. Quality control
    d. Financial Data, and
    e. Performance regarding accreditation, recognition, or other administrative requirements.

5. Medical record review (to include peer review, coding, and completeness auditing);
6. Implementation of Joint Commission Standards for Ambulatory Care;
7. The incorporation of the Bureau of Primary Health Care's *Clinical Outcome Measures* monitoring and reporting program, and
8. Evaluation of clinical practice guidelines regarding compliance, variation and continuous development.
9. Implementation and maintenance of NCQA/PCMH standards for collaborative holistic patient-centered care provision.

V.Governance & Leadership:

The Board of Directors is responsible and accountable for the quality of all services delivered by Three Lower Counties Community Services. The Board of Directors authority and accountability is delegated to the Chief Executive Officer and the Medical staff for developing, implementing, and maintaining a viable performance improvement program.

The Medical Director is responsible for providing necessary leadership, education, guidance, and support within the limits of resources available to maintain an ongoing program of performance improvement.

The Medical Staff of TLCCS, under the direction of the Medical Director, is responsible for taking a leadership role in processes that are the primary responsibility of physicians, advanced practice providers, and actively participate in organization-wide performance improvement activities **(see P.I. form 1.B.)**.

A.Medical Staff Executive Committee:

Oversight and approval of the PI Plan is further delegated by the CEO to the Medical Staff Executive Committee, which has responsibilities for oversight of the quality of medical care rendered to Three Lower County Community Services patients. The Medical Staff shares responsibility with the CEO and Administration for developing and reviewing clinically appropriate policies and recommending standards for other TLCCS staff whose conduct directly influences the quality of patient care.

The Medical Staff Executive Committee is responsible for:

1. Assisting and participating in the development, implementation, and evaluation of ongoing performance improvement program;

2. Selecting and reviewing clinical indicators and criteria for use in peer review and in evaluating patient care quality;
3. Participating in and providing support to interdisciniplinary performance improvement teams to foster integration, input, and problem solving at all levels of the organization;
4. Reviewing and providing input and feedback to departments and services;

B. Med Review Committee

The Med Review Committee is responsible for:

1. Recommending clinical privileges; and
2. Recommending medical staff for appointment and reappointment
3. Discussion and action on provider performance issues
4. Discussion and action on patient behavioral/discharge issues

C.Performance Improvement Committee:

The Performance Improvement Committee has been established as an oversight committee to provide leadership and guidance for improving the organization's performance. The P.I. Committee consists of the following individuals: the Chief Medical Officer, the Director of Nursing, P.I. Coordinator, Pharmacist, Corporate Nurse, Chief Development Officer, PCMH Nurse Care Coordinator and the COO.

The Performance Improvement Committee has responsibilities for:

1. Oversight and establishing/resetting priorities for TLCCS comprehensive, interdisciniplinary Performance Improvement Program;
2. Development of an environment that encourages and empowers staff to identify and address issues through the PI process;
3. Empowerment of committees to identify opportunities, design performance improvement activities and resolve issues;
4. Assurance of compliance with JC accreditation standards, NCQA/PCMH standards, and regulatory agency requirements;
5. Reporting to the Medical Staff Executive Committee on performance improvement initiative, goals, and significant issues;
6. Establishing organization-wide PI measures that are strategically aligned;
7. Assessing resource utilization, provide oversight and recommendations as needed; and
8. Reviewing and providing oversight for sentinel event root cause analyses.

The PI Committee has the delegated responsibilities for coordination, integration, and ongoing monitoring of the organization's performance to improve and sustain quality of patient care processes and care.

D.Performance Improvement Coordinator:

The Performance Improvement Coordinator is primarily responsible for recommending, implementing, and monitoring PI activities throughout TLCCS. The Performance Improvement Coordinator reviews and integrates PI efforts across the organization and ensures that activities throughout the organization are consistent with the priorities established by leadership.

The Performance Improvement Coordinator is responsible for:

1. Monitoring quality-related functions including PI and policy development;
2. Facilitating dissemination, discussion and understanding of performance improvement data;
3. Educating employees in PI principles and processes;
4. Coordinating and integrating the various quality and organizational performance activities and measurements throughout the organization;
5. Obtaining input for problem-identification from administrative reports including incident reports and survey findings from professional organizations such as the Joint Commission;
6. Evaluating the PI program annually and making recommendations for organization-wide PI indicators and;

7. Identifying opportunities where interdisciniplinary approaches are needed to efficiently and efficaciously resolve problems;
8. Determine patterns and trends in patient services/outcomes promptly identify important opportunities for improvement, and modification of existing treatment, care and service processes.

VI. Performance Improvement Measures:

Performance measures for processes that are known to jeopardize the safety of the population served or associated with sentinel events will be routinely monitored. At a minimum performance measures related to the following processes, as appropriate to the care and services provided are monitored with the approval, and at the suggested frequency of the Performance Improvement Committee **(see P.I. form 1.D)**:

1. Management of hazardous conditions (including identification and resolutions, as appropriate)
2. Medication use (including medication errors and adverse drug reactions)
3. Patient Centered Care or services provided to high risk populations
4. Staffing effectiveness
5. The appropriateness and effectiveness of pain management
6. Recommendations for the achievement of The National Patient Safety Goals
7. Patient Flow
8. Continuum of Care
9. Peer review activities
10. Performance Improvement priorities and processes set forth by regulatory, recognition and accrediting agencies (to include Joint Commission and NCQA/PCMH standards)

VII. Performance Improvement Methodology:

In order to maintain a framework for organized, ongoing and systematic measurement TLCCS utilizes the PDSA quality improvement methodology-**(see P.I. form 1.A)**

VIII. Education:

The Performance Improvement Committee assures that medical staff, leadership, and employees receive training in Performance Improvement methods and tools. Performance Improvement information is included in the new employee orientation program and is a component of the annual mandatory educational requirements. Furthermore, the Performance Improvement Department provides training to ensure that all employees are aware of the interdisciniplinary PI activities currently underway and that each is aware of the opportunities and resources available to support their PI efforts.

IX.Confidentiality:

Confidentiality is essential to the Performance Improvement Process. Deliberations of the Performance Improvement Committee, Medical Staff Executive Committee and other Medical Staff committees and teams where Performance Improvement issues have been discussed are excluded from outside review. Additionally, names of specific individuals (patients, physicians, staff, etc.) will be withheld from all reports. Performance Improvement data and reports are maintained in locked files.

X. Evaluation:

The effectiveness of the Performance Improvement Plan will be evaluated by the Performance Improvement Committee and reported annually to the Board of Directors. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

PERFORMANCE IMPROVEMENT PLAN – February 2014

Respectfully submitted by the Management Team:

Susanne M Gray — 5/20/14

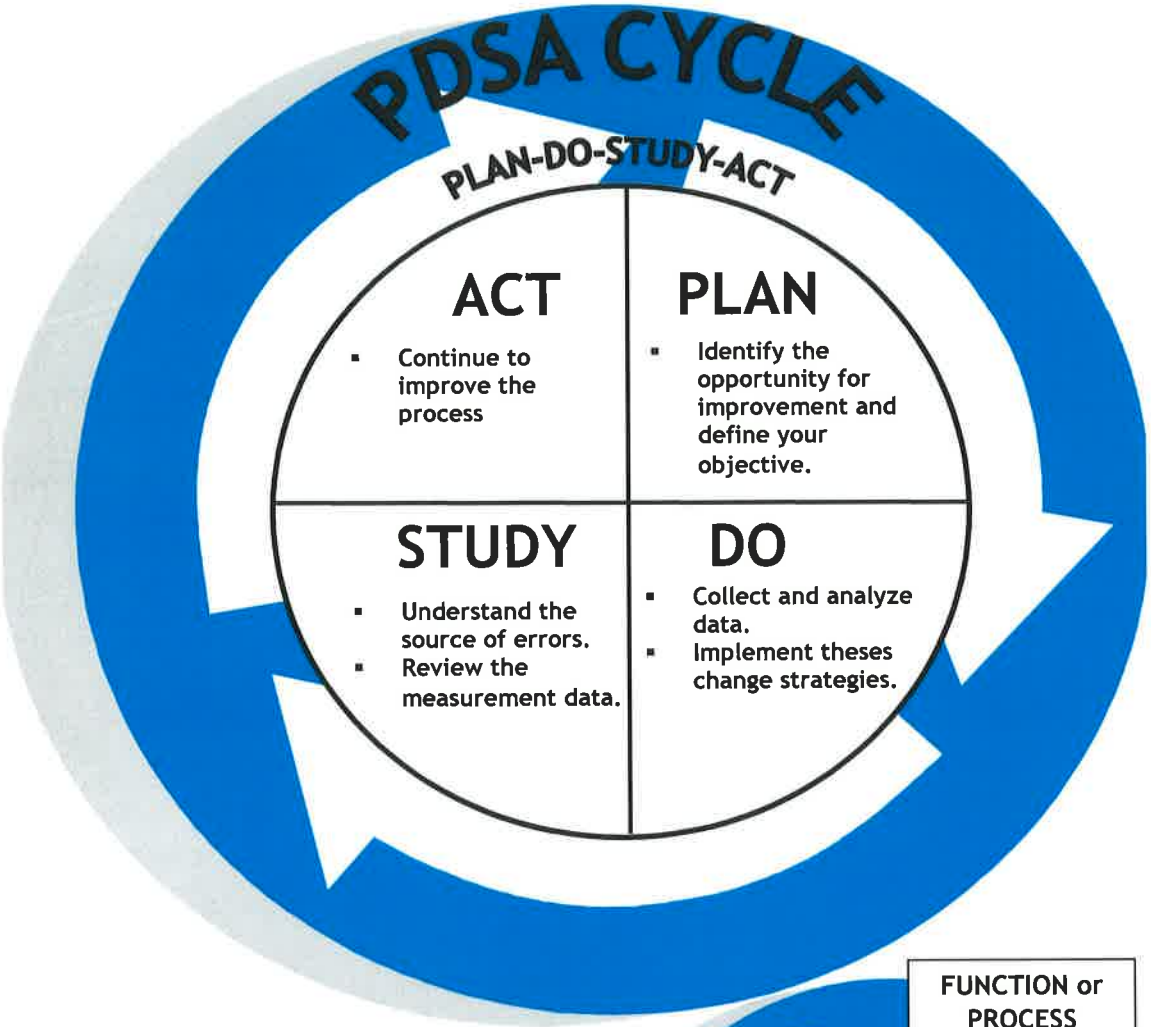
President/CEO — Date

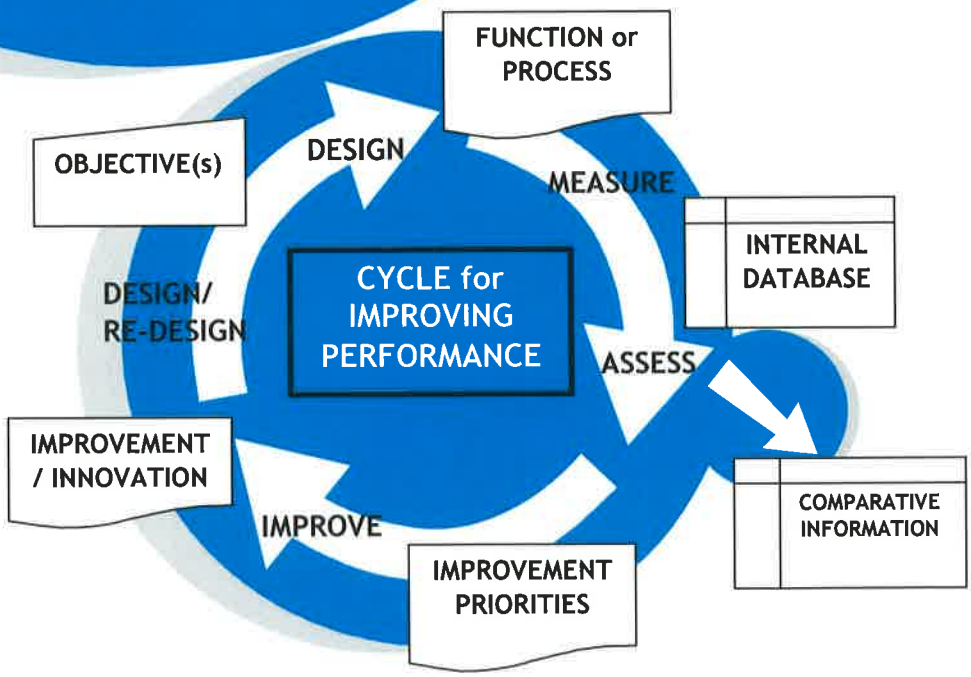
5/15/14

Board of Directors President — Date

P.I. 1.A

Performance Improvement Methodology:





While the above methodologies will be customarily employed, the organization may implement alternative improvement methodologies when called for by the issue being studied.

P.I. 1.A

PDSA: Model For Improvement

CYCLE FOR LEARNING AND IMPROVEMENT
OBJECTIVE: **PLAN:** ***QUESTIONS:*** ***PREDICTIONS:*** ***PLAN FOR CHANGE OR TEST:*** ***PLAN FOR COLLECTION OF DATA:***
DO:
STUDY:
ACT:

Adapted from the Institute for Healthcare Improvement

PDSA Template

FLOW CHART FOR DATA REPORTING

Committee Meetings PI, IC, EOC, PI	Bi-Monthly	COO, CMO, CCO
PCMH Meetings	Monthly	COO, CMO, CDO
Clinical Department Meetings Internal Medicine, Pediatrics, OB/GYN, Dental, Mental Health	Monthly	COO, CMO, CCO
Corporate Department Meetings		
Human Resources	As Needed	CDO
Staff Development	As Needed	CDO
Billing	As Needed	CFO
Accounting	As Needed	CFO
Leadership Meetings	Weekly	Consists of CEO, CMO, CCO, CDO, CFO, ACMO
Board of Directors	Monthly	Specific Department/Committee Reports to BOD may be monthly quarterly, semi-annually, or annually. CEO, CMO, CFO, CAO/CCO, CDO

Three Lower Counties Community Services, Inc.

Form P I 1.C

QA / RA / PI/ EH ACTIVITIES					
Type of Data	**Frequency Obtained**	**Responsibility**	**Frequency Reported**	**Reported To**	**Data Location**
EOC Plan Review / Hazard Vulnerability Analysis	Annually	Safety Officer & PI Coordinator	Annually	CMO	PI office
Autoclave / Autoclave Spore Testing	Variable	Corporate Nurse, Dental staff / OB-GYN staff, WB	Bi-Monthly	EOC/Infection Control Committee	Sites, Corporate Nurse
Medical Record Completeness Audit	Quarterly	Performance Improvement / Medical Records	Quarterly	CMO / Providers	PI Coordinator
Clinical Peer Review	Quarterly	Providers / Medical Director / PI	Quarterly	CMO / Providers	PI Coordinator
Medical Record Coding Audits	Quarterly	CFO/Billing Manager	Quarterly	CMO/PI / Med Ex	CFO
Comprehensive Risk Assessment	Semi-Annually	Clinical Managers	Semi-Annually	EOC Committee	At Sites
Crash Cart, AED / Defibrillator, O_2 Tank Inspection, Suction	Daily	Corporate Nurse, Clinical Managers	Bi-Monthly	PI / CMO	Crash Cart, Corporate Nurse, Pharmacy
Critical Lab/Test Values Log	Daily	Clinic Staff / Clinical Manager / Corporate Nurse	Bi-Monthly	PI / CMO	Corp. Nurse
Disaster Drill	Annually	Clinical Managers	Annually	EOC Committee	At Sites
Fire Drills	Annually	Clinical Managers	At least one per year	EOC Committee	At Sites
Hand Hygiene	Annual Training	Infection Control / PI/ Corporate Nurse	Bi-Monthly & Review annually	PI / Infection Control & EOC Committees, Corporate Nurse	Human Resources
Hazard Surveillance / Risk Assessment	Quarterly	Clinical Managers/Safety Officer	Quarterly	EOC Committee	At Sites
Health Center Acquired Infection Surveillance / Monitoring (Dental Extraction, Biopsy Procedures)	Ongoing	Infection Control / Corporate Nurse	Monthly Monitors / Bi-Monthly Report	Infection Control / EOC Committees /CMO	Corp. Nurse
Incident Reports	Ongoing	All TLC Staff / PI	Bi-Monthly	Reviewed at EOC Committee	Beaver Run
Refrigerator Temperature	Twice Daily	Clinical Staff /Clinical Manager/ Pharmacy/ Corporate Nurse	Bi-Monthly	Infection Control/EOC /P&T Committees	Sites, Corporate Nurse
Staff Influenza Vaccination or Declination	Seasonal	PI / IC	Annually	IC/EOC/P&T/PI	Corp. Nurse

Anticoagulation Monitoring	Quarterly	PI / Adult Dept. Head	Quarterly	PI / CMO / Med Ex	PI
ICP Review / Summary	Annually	Corp. Nurse / PI	Annually	IC/EOC/P&T/PI/ CMO/ Med Ex /BOD	Corp. Nurse
Leaded X-Ray Aprons	Annually	Lead DA	Annually	Director of Dental Administration	Dental
Monthly Safety Checklist	Monthly	Clinical Managers / Safety Officer / PI	Bi-Monthly	EOC Committee	At Sites
Blood & Body Fluid Exposure Incidents & Follow-up	Per Occurrence	Corporate Nurse / Providers / Infection Control	Bi-Monthly	Corporate Nurse / CMO / Infection Control / EOC Committees	Sharps Log, Corporate Nurse
Patient Satisfaction Survey	Bi-annually	CMO/PI	Bi-Annually	EOC/PI/CMO/ Med Ex / BOD	Beaver Run
Pro-Active Risk Assessment	Annually & As Identified	All Departments / All Committees	Annually & As Identified	Med Exec Committee	Performance Improvement Manual
Provider Satisfaction Survey	Every Three Years	HR	Annually	Med Exec Committee	Human Resources
Sentinel Events	As Identified	CMO	As Identified	Med Review	PI Office
Staff Satisfaction Survey	Every Three Years	HR	As performed	Med Exec Committee	Human Resources
Provider Performed Microscopy Proficiency	March, June, October	Corporate Nurse	April, July, November	Medical Director	Corporate Nurse
Emergency Referral Log	Daily	Clinical Staff / Corp. Nurse	Bi-Monthly	Medical Director / Providers	Sites, Corp. Nurse
Sample Medications Logs & Reconciliation	Monthly	Clinical Staff	Bi-Monthly	PI / CMO	Sites
Stock Medications Logs & Reconciliations	Monthly	Clinical Staff	Bi-Monthly	PI / CMO	Sites
EHR Meaningful Use	Ongoing	Athena Liaison,CDO, Clinical Staff	Quarterly	CMO, CEO, Med Exec Committee, Board of Directors	Beaver Run, athenaHealth
Patient Centered Medical Home	Ongoing	CEO, CMO, PI Committee, PCMH Coordinator	Quarterly	PI Committee, Med Exec Committee, Board of Directors	Beaver Run
Nitrous Badges	Quarterly	Director of Dental Administration	Quarterly	Director of Dental & Monitoring Co.	Dental
Clinical Staff (RN/LPN/MA/Lab) Competencies	Annually	Clinical Manager / HR	Annually	HR / CMO	HR
Dental Assistant Competencies	Annually	Lead DA/Dept. Head	Annually	HR / CMO	HR
N95 Respirator Mask Fittings	Annually	Corp. Nurse / Clinical Manager	Annually	PI/EOC/IC/P&T	Corp. Nurse
Medication Formularies	Annual Review	P&T / CCO	Bi-Monthly Updates	PI/EOC/IC/P&T	CCO

Form PI 1.D

TLCCS PERFORMANCE MEASURE		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #1	Hypertension ≤ 140/90	48.57%	67.14%	58.57%	71.43%	33%	63.57%	75%
Target Goal	By 2017, increase the % of adult patients, 18 years and older with a diagnosis of hypertension whose blood pressure was less than 140/90 from 67.14 % to 70 %							
Numerator Description	All pts. 18 - 85 years of age as of December 31st of the measurement year with a dx of hypertension and have been seen at least twice during the report year in the office.							
Denominator Description	Patients 18 - 85 years with a dx of hypertension with most recent systolic blood pressure measurement ≥140mm Hg and a diastolic blood pressure ≥90 mm Hg.							

TLCCS PERFORMANCE MEASURE		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #2	Childhood Immunization (ages 0-24)	81.43%	82.86%	87.14%	67.14%	66%	91.43%	90%
Target Goal Description	By 2017, increase the % of children by 2 years of age with appropriate immunizations from 82.86% to 85%.							
Numerator Description	Number of children in the universe who received all of the following: 4 DTP/DTaP, 3 IPV, 1MMR, 2 Hib, 3 HepB, 1VZV, 2 HepA, 2-3 Rotavirus, 2 Influenza and 4 Pneumoccocal conjugate, prior to or on their 3rd birthday whose third birthday occurred during the measurement year(prior to December 31st), among those children included in the denominator. Measure changed for 2011 to include 2 Influenza vaccines and 2-3 Rotavirus vaccines.							
Denominator Description	Number of children with at least one medical encounter during the measurement period, who had their third birthday during the reporting period, who did not have a contraindication for a specific vaccine, who were seen for the first time in the office prior to their third birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.							

TLCCS PERFORMANCE MEASURE		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #3	Pap Tests (ages 21-64)	77.14%	81.43%	81.43%	74%	73%	74.29%	85%
Target Goal Description	By 2017, increase the % of women 21-64 years of age who received one or more Pap tests from 81.43% to 85%							
Numerator Description	Number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.							
Denominator Description	Number of female patients age 24-64 years of age during the measurement year who were seen for a medical encounter at least once during the reporting period.							

TLCCS PERFORMANCE MEASURE		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #4	Prenatal Care (Entry during 1st trimester)	84.99%	89.56%	90.73%	84.3%	85%	85.25%	90%
Target Goal Description	By 2017, increase the % of pregnant patients beginning prenatal care in the 1st trimester of pregnancy from 89.56% to 91%							
Numerator Description	All female patients who received prenatal care during the measurement year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.							
Denominator Description	Number of female patients who received prenatal care during the measurement year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was completed and does not include a visit at which pregnancy was diagnosed or one where initial tests were completed or vitamins were prescribed.							

TLCCS PERFORMANCE MEASURE		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #5	Low Birth Weight (less than 2,500 grams)	6.01%	10%	7.21%	7.24%	7.41%	7.78%	6%
Target Goal Description	By 2017, decrease the % of births less than 2,500 grams to health center patients from 10% to 8%.							
Numerator Description	Women in the universe whose child weighed less than 2,500 grams during the measurement year, regardless of who performed the delivery.							
Denominator Description	Total births for all women who were seen for prenatal care during the measurement year, regardless of who performed the delivery.							

TLCCS PERFORMANCE MEASURE		2011 Baseline	2012	2013				Projected Data
Focus Area #6	Child weight assessment and counseling	31%	79%	67.14%				85%
Target Goal Description	To increase weight assessment and counseling for our pediatric and adolescent patient population							
Numerator Description	Children aged 3-17 with a medical visit in the last year with documentation of BMI percentile, counseling for nutrition, and counseling for physical activity							
Denominator Description	All Children ages 3-17 with a medical visit in the last year.							

TLCCS PERFORMANCE MEASURE		2011 Baseline	2012	2013	2014			Projected Data
Focus Area #7	Adult weight assessment and follow-up	37%	61%	65.71%				50%
Target Goal Description	To increase weight assessment and counseling for our adult population.							
Numerator Description	Adults aged 18 and older, with a medical visit in the last year who had their BMI documented within six months of their last visit, with a follow-up plan documented if BMI is outside recommend parameters.							
Denominator Description	All adults aged 18 and older with a medical visit in the last year.							

TLCCS PERFORMANCE MEASURE		2011 Baseline	2012	2013	2014			Projected Data
Focus Area #8	Asthma Pharmacologic Therapy	87%	70%	94.29%				20%
Target Goal Description	To increase the number of patients with persistent asthma on pharmacologic therapy							
Numerator Description	Number of patients in the denominator who received a prescription for or were provided inhaled corticosteroid or an accepted alternative medication.							
Denominator Description	Sample of patients who were between 5 and 40 years of age at some point during the measurement year, who have been seen at least twice in the practice and who had at least one medical visit during the reporting year, who had an active diagnosis of persistent asthma.							

TLCCS PERFORMANCE MEASURES		2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #9	Monitor HbA1c ≤9-	82.86%	68.57%	71.43%	65.71%	56%	61.29%	84%
Target Goal	By 2017, increase the % of adult patients with Type I or II diabetes, whose most recent HbA1c is ≤ 9% from 68.57% to 70%							
Numerator Description	Number of adult pts age 18-75 years with diagnosis of Type I or II diabetes whose most recent HbA1c level during the measurement year is ≤ 9%, among those pts. included in the denominator							
Denominator Description	Number of adult pts age 18-75 years as of December 31st of the measurement year with a diagnosis of Type I or II Diabetes, who have been seen in the office at least twice during the reporting year and do not meet any of the exclusion criteria.							

TLCCS PERFORMANCE MEASURES		2010	2011 Baseline	2012	2013			Projected Data
Focus Area #10	Tobacco Use Assessment	N/A	98.57%	100%	97.15%			75%
Target Goal	By 2017, increase the percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months.							
Numerator Description	Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit or within 24 months of the most recent visit.							
Denominator Description	Sample of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever.							

TLCCS PERFORMANCE MEASURES			2008 Baseline	2009	2010	2011	2012	2013	Projected Data
Focus Area #11	Tobacco Education & Cessation		New measure		N/A	83%	59%	64.29%	35%
Target Goal			By 2017, increase the percentage of tobacco education and cessation for patients that use any and all forms of tobacco products.						
Numerator Description			Number of patients in the denominator who received tobacco cessation counseling or smoking cessation agents during their most recent visit or within 24 months of the most recent visit.						
Denominator Description			Sample of patients who were 18 years of age or older during the measurement year, seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty four months who had at least one medical visit during the reporting period, and at least two medical visits ever.						

TLCCS PERFORMANCE MEASURES			2010	2011	2012 Baseline	2013			Projected Data
Focus Area #12	Lipid Therapy		N/A	N/A	87.14%	91.43%			75%
Target Goal			By 2017, at the end of the measure period is 75%.						
Numerator Description			Patients aged 18 and older in the denominator who received a prescription for or were taking lipid-lowering medications.						
Denominator Description			Number of patients 18 years of age or older who were seen during the measurement year who had at least one medical visit during the reporting year, with at least two medical visits ever, and who had an active diagnosis of coronary artery disease.						

TLCCS PERFORMANCE MEASURES			2010	2011	2012 Baseline	2013			Projected Data
Focus Area #13	Aspirin/Antithrombotic Therapy		N/A	N/A	88.57%	71.43%			70%
Target Goal			By 2017, at the end of the measure period is 70%.						
Numerator Description			Number of patients 18 years of age or older during the measurement year who had documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed or used.						
Denominator Description			Number of patients 18 years of age or older during the measurement year who had at least one medical visit during the reporting year who were identified with a diagnosis of ischemic vascular disease or AMI, CABG, or PTCA procedure with aspirin or antithrombotic therapy.						

TLCCS PERFORMANCE MEASURES			2010	2011	2012 Baseline	2013			Projected Data
Focus Area #14	Colorectal Cancer Screening		N/A	N/A	41.43%	60%			55%
Target Goal			By 2017, at the end of the measure period is 55%.						
Numerator Description			Number of patients aged 51 - 74 with appropriate screening for colorectal cancer screening.						
Denominator Description			Number of patients aged 51 - 74 and had one medical visit during the reporting year.						
TLCCS PERFORMANCE MEASURES			**2010 Baseline**	**2011**	**2012**	**2013**			**Projected Data**
Focus Area #15	Dental Treatment Plans		75%	60%	78%	78%			75%
Target Goal			By 2017, at the end of the measure period is 75%.						
Numerator Description			Number of patients 3-12 years of age who were monitored for completed dental treatment plans during the measurement period.						
Denominator Description			Number of children ages 3-12 years monitored for completed dental treatment plans.						
TLCCS PERFORMANCE MEASURES			**2010 Baseline**	**2011**	**2012**	**2013**			**Projected Data**
Focus Area #16	Behavioral Health		5.69%	2.90%	2.85%	2.85%			5%
Target Goal			By 2017, at the end of the measure period is 5%.						
Numerator Description			Number of hours children in behavioral health absent from school.						
Denominator Description			Number of hours children in behavioral health in school.						