St. Mary's of Michigan Implementation Strategy

Implementation Strategy Narrative

Overview

St. Mary's of Michigan is a regional leader in advanced specialty care, offering comprehensive services in the cardiac sciences, neurosciences, cancer care, orthopedics, emergency and trauma care. St. Mary's is a verified Level II Trauma Center and certified Primary Stroke Center. With 268 beds and over 20 specialty centers in Saginaw, Bay City, Birch Run, Chesaning, Frankenmuth, Marlette, Standish, Tawas, Vassar and West Branch, St. Mary's has established itself as a technological pioneer and patient advocate throughout the state. Patients are cared for from 70+ counties, primarily the mid, northern and thumb regions of Michigan. Over 60% of our patients come from outside Saginaw County. A member of Ascension, the largest non-profit health system in the U.S. and the world's largest Catholic health system, St. Mary's of Michigan is dedicated to healthcare transformation by providing the highest quality care to all, with special attention to those who are poor and vulnerable. At St. Mary's of Michigan, we continue to grow our outreach and expand our vision. Our medical advancements in cardiac sciences, neurosciences, oncology, and trauma are rivaled only by our passion. Our compassion to heal body, mind and spirit.

The Saginaw County Community Health Needs Assessment and Health Improvement Plan 2017 – 2020 was an initiative of Alignment Saginaw Community Health Improvement Plan (CHIP) Partners. Alignment Saginaw is a community collaborative with a mission of preparing and mobilizing around opportunities that impact key areas affecting Saginaw County's quality of life. From September 2016 through January 2017, members of the Saginaw County CHIP Partners, including the two separate hospital systems, and a collection of multi-sector community stakeholders, completed the joint CHNA for Saginaw County. Information regarding Saginaw County's most important health needs, as well as their prioritization, are based upon information provided by residents using the four Mobilizing for Action through Planning and Partnerships (MAPP) assessments: 1) community health status, 2) community themes and strengths, 3) local public health system, and 4) forces of change. In an attempt to acquire broad community input regarding the health needs of Saginaw County, individuals who live and/or work in Saginaw County, including residents, health care consumers, community leaders, health care professionals, and multi-sector representatives, were interviewed, participated in meetings of CHIP's network of community partners, and/or responded to one of the MAPP surveys. These findings are also informed by a collection of over 100 metrics designed to measure health status and chronic disease priorities, social and economic factors impacting residents, and healthcare delivery system access and utilization trends experienced in the County.

The joint community health needs assessment identified eight priority health needs for Saginaw County. The needs were prioritized based upon, input gathered from the CHNA, the implications for long term health outcomes, the ability of local health care systems to have an impact on addressing the need, current priorities and programs, and the effectiveness of existing programs. The identified priorities for Saginaw County include:

1. Obesity
2. Chronic Illnesses: Diabetes, Cancer, Heart Disease, Asthma
3. Dental Health
4. Maternal, Infant, & Child Health
5. Substance Abuse/Misuse
6. Mental Health
7. Equal Access to Healthy Choices & Opportunities
8. Access to Health Care and Utilization of Services

St. Mary's leadership in collaboration with the St. Mary's CHNA Implementation Strategy Committee then decided to prioritize and address five of the eight identified community needs:

Prioritized Needs

Priority 1: Obesity & Chronic Illnesses

Rationale: Overall, Saginaw county's health behaviors are some of the poorest in the state ranking 74th out of 83 Michigan counties. Saginaw County's top two causes of death in 2014 were heart disease and cancer. Saginaw County's rates of death due to chronic lower respiratory diseases, diabetes, pneumonia/influenza, and kidney disease are higher than the state's. In 2015-2017 the percentage of Saginaw County obese and overweight adults was 73.1%. Only 25.0% of Saginaw County adults get adequate physical activity, and 11.7% consume adequate amounts of fruits and vegetables. The percentage of Saginaw County's obese and overweight students for 2015-2016 was 36.8% for middle schoolers, and 33.8% for high schoolers. Almost 63% of the Saginaw County residents and employees who participated in a Community Themes and Strengths Assessment (survey) selected obesity as a health issue in most serious need of attention. Saginaw County's diabetes prevalence (11.0%) is higher than the state (9.48%) and national (9.11%) averages. Diabetes is a significant health status indicator and high cost disease.

Strategy: Serve as a vital presence in the community to support physical activity and access to and consumption of healthy food via programming that meets community health needs and supports population health delivery – improved outcomes, enhanced patient & provider experience, and lower costs. St. Mary's will address obesity/chronic illness and support healthy lifestyles among adults and children through our established and dedicated pre-diabetes programs, diabetes programs, support groups, exercise programs, and one on one healthy lifestyle coaching.

Priority 2: Mental Health

Rationale: Mental health is an important indicator of health outcomes, and a serious concern in the Saginaw community. The percentage of Saginaw County residents reported as having poor mental health days increased between 2008-2010 and 2013-2015 reporting periods to 15.4%. 24.4% of Saginaw County residents were reported being told that they were depressed.

Strategy: St. Mary's Center of Hope will serve the community through collaborating with the Saginaw Community Mental Health Authority. St. Mary's will address mental health and support healthy lifestyles among adults through offering Personal Action Toward Health (PATH) classes and encouraging participants to become involved in other free healthy lifestyle and exercise programs.

Priority 3: Equal Access to Healthy Choices & Opportunities

Rationale: Saginaw County ranks 74th out of 83 Michigan counties for overall health outcomes, including 70th in length of life, and 79th in quality of life. Saginaw County ranks 73rd for overall health factors, including 78th in health behaviors, 70th in physical environment, and 60th in social/economic factors. Many of Saginaw County's communities of color and low-income communities are overwhelmed with harmful attributes that compromise individual and community health. Moreover, all demographic, social, and economic impact factors are higher among residents within the City of Saginaw, where higher rates of poverty are associated with poorer educational outcomes, income levels, employment levels, crime/incarceration, and inadequate access to health care/coverage. Residents who are low-income, minority, or un/underinsured are disproportionately impacted by environmental issues such as pollution, crime, property abandonment, lack of areas to exercise outdoors, and lack of access to healthy foods. Saginaw County's 2015 poverty rate (18.3%) slightly exceeds that of the state (16.7%).

Strategy: The Center of Hope will serve as a vital presence in the community to provide opportunities for physical activity, access to and consumption of healthy food via programming, and healthy lifestyle classes that meet community health needs and supports population health delivery – improved health outcomes, enhanced patient & provider experience, and lower costs. St. Mary's will address poverty access inequities

through offering the following programs and services free to the community: Healthy Gatherings, Healthy Lifestyle Your Way, “You Pick It” farmers market tours, Cooking Matters, Exercise Classes (Yoga, Walking Club, Enhanced Fitness, Hustle Aerobics) and access to washer/dryer, fitness room, kitchen, and the Community Garden.

Priority 4: Access to Health Care and Utilization of Services

Rationale: The Community Themes and Strengths survey revealed that 14% of those polled did not have any kind of health care coverage, and 21% do not have a health care provider. Many Saginaw County residents have expressed that the need for quality, affordable health care is the most important issues that should be addressed in the community. There are 641,000 veterans in the state of Michigan, of the Veterans who reside in Michigan, almost half (327,000) are age 65 and older. Michigan ranks 47th out of 53 states and territories for average dollars spent on Veterans. There is a slow and difficult enrollment process for services and significant service gaps as the number of Veterans in the state continues to grow.

Strategy: St Mary’s will increase access to affordable health care, health insurance, and quality health services delivered to uninsured and underserved populations. St. Mary’s will also partner in supporting Veterans Affairs programs to improve services to Veterans that are aligned with population health care delivery and better health, improved patient experience and reduced cost through the Veterans Choice Program. St. Mary’s will develop and implement an evidence-based standard of care to expand awareness and scope of Advance Care Planning and Advance Directives to Saginaw County residents and providers. St. Mary’s will reevaluate operations and services and determine eligibility for the Center of Hope Free Clinic’s and Community Benefit Pharmacy.

Needs That Will Not Be Addressed

St. Mary’s will not directly address the following focus areas/priorities identified within the 2017 CHNA: Dental Health, Maternal, Infant & Child Health, and Substance Abuse/Misuse. While critically important to overall community health, these specific priorities did not meet internally determined criteria that prioritized addressing needs by either continuing or expanding current programs, services and initiatives to steward resources and achieve the greatest community impact. For the three areas not chosen, there are other service providers in the community better resourced to address these priorities. St. Mary’s will work collaboratively with these organizations as appropriate to ensure optimal service coordination and utilization.

Summary of Implementation Strategy

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy. See attached action plans for each priority area.

Prioritized Need 1: Obesity & Chronic Illnesses

GOAL: Leveraging the strengths of Ascension Mid-Michigan's current diabetes, nutrition, and lifestyle programs, SMOM will provide chronic disease prevention and management education and resources at the right service, right place, right time by refining the structure and process to support improved health outcomes.

Action Plan: Chronic Disease Care Pathways

STRATEGY 1: Develop and implement care pathways for chronic disease care coordination (programs include: Diabetes Prevention Program (DPP), Diabetes Self-Management Education (DSME), Diabetes Personal Action Toward Health (PATH), Diabetes Medical Nutrition Therapy (MNT), and healthy lifestyle programs)

BACKGROUND:

- **Target Population:** Individuals identified/diagnosed with chronic disease, or those who are in need of an intervention to prevent the onset of chronic disease.
- **How the strategy addresses the social determinants of health, health disparities and challenges of the underserved:** Overall, Saginaw county's health behaviors are some of the poorest in the state ranking 74th out of 83 Michigan counties. Saginaw County's top two causes of death in 2014 were heart disease and cancer. Saginaw County's rates of death due to chronic lower respiratory diseases, diabetes, pneumonia/influenza, and kidney disease are higher than the state's. In 2015-2017 the percentage of Saginaw County obese and overweight adults was 73.1%. Only 25.0% of Saginaw County adults get adequate physical activity, and 11.7% consume adequate amounts of fruits and vegetables. The percentage of Saginaw County's obese and overweight students for 2015-2016 was 36.8% for middle schoolers, and 33.8% for high schoolers. Almost 63% of the Saginaw County residents and employees who participated in a Community Themes and Strengths Assessment (survey) selected obesity as a health issue in most serious need of attention. Saginaw County's diabetes prevalence (11.0%) is higher than the state (9.48%) and national (9.11%) averages. Diabetes is a significant health status indicator and high cost disease.
- **Strategy Source:** The following chronic disease and healthy lifestyle programs are evidence based: DPP http://dpacmi.org http://www.cdc.gov/diabetes/prevention/lifestyle-program/index.html, DSME http://dpacmi.org www.diabetes.org, Diabetes and Chronic Disease PATH http://patienteducation.stanford.edu

RESOURCES:

- CDC, Self-Management Resource Center

COLLABORATION:

- Physician Hospital Organization (PHO), Ascension Medical Group (AMG), SMOM Diabetes and Wound Care, Center of Hope, Community Mental Health

ACTIONS:

1. SMOM will develop an algorithm for chronic disease care coordination.

2. SMOM will revise and update the DPP Playbook to include algorithm and navigator roles and responsibilities.

STRATEGY 1: Develop and implement care pathways for chronic disease care coordination (programs include: Diabetes Prevention Program (DPP), Diabetes Self-Management Education (DSME), Diabetes Personal Action Toward Health (PATH), Diabetes Medical Nutrition Therapy (MNT), and healthy lifestyle programs)
3. SMOM will distribute algorithms and DPP Playbook to PHO and AMG to educate providers on appropriate referrals.
ANTICIPATED IMPACT: **Short term** I. Chronic disease care coordination algorithm is created and integrated into DPP Playbook. **Medium Term** II. PHO and AMG provider offices are educated on care pathways. Referrals are tracked and evaluated. **Long Term** III. Referrals increase by 5%.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
Reduce the number of patient diagnosed with pre-diabetes Reduce the number of patients who develop type 2 Diabetes Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who are at risk for, DM. (HP2020)	Critical Success Factor 3 (Population Health) Strategic Objective 7 (Pilot standardized diabetes care model Community Needs Assessment: Obesity/Overweight/Health Life Style	Same	**Health People 2020:** **1. Nutrition and Weight Status:** Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. **2. Educational and Community-Based Programs:** Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life NATIONAL DIABETES PREVENTION PROGRAM **Ascension Population Health/Fee-for-Value** focused on optimal patient outcomes, enhance patient and provider experience, and lower cost (quadruple aim)

Prioritized Need 2: Mental health

GOAL: St. Mary's Center of Hope will serve the community through collaborating with the Saginaw Community Mental Health Authority. St. Mary's will address mental health and support healthy lifestyles among adults through offering Personal Action Toward Health (PATH) classes and encouraging participants to become involved in other free healthy lifestyle and exercise programs.

Action Plan: Chronic Disease PATH

STRATEGY 1: Collaborate with Saginaw County Community Mental Health Authority to offer Chronic Disease PATH classes at the Center of Hope and at Saginaw County Community Mental Health Authority.

BACKGROUND:

- **Target Population:** Saginaw County Community Mental Health Authority consumers who have been diagnosed with chronic disease or have the potential to develop a chronic disease.
- **How the strategy addresses the social determinants of health, health disparities and challenges of the underserved:** Mental health is an important indicator of health outcomes, and a serious concern in the Saginaw community. The percentage of Saginaw County residents reported as having poor mental health days increased between 2008-2010 and 2013-2015 reporting periods to 15.4%. 24.4% of Saginaw County residents were reported being told that they were depressed.
- **Strategy Source:** Chronic Disease PATH is an evidence based program. http://patienteducation.stanford.edu

COLLABORATION:

- Saginaw County Community Mental Health Authority, Self-Management Resource Center

ACTIONS:

1. SMOM will provide 1-2 Chronic Disease PATH workshops per year and encourage participants to become involved in other healthy lifestyle programs/activities.
2. SMOM RN and Mission Coordinator will receive Chronic Disease PATH master certification.
3. SMOM RN and Mission Coordinator will train new Chronic Disease PATH leaders.
4. SMOM RN and Mission Coordinator will begin teaching Chronic Disease PATH at Saginaw County Community Mental Health Authority for those consumers who have transportation barriers.

ANTICIPATED IMPACT:

Short Term

I. SMOM RN and Mission Coordinator have achieved master certification in Chronic Disease PATH.

Medium Term

II. 3-5 new Chronic Disease PATH leaders have been trained.

Long Term

III. At least 1 Chronic Disease PATH class had been conducted at Saginaw County Community Mental Health Authority.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
			Ascension: Population Health/ Fee for Value focused on Optimal Patient Outcomes, Enhanced Patient & Provider Experience, and Lower Cost
			HP 2020: Mental Health and Mental Disorders: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral; Increase the proportion of children with mental health problems who receive treatment; Emerging issue is people in communities with large-scale psychological trauma caused by natural disasters (Flint Water Crisis)

Prioritized Need 3: Equal Access to Healthy Choices & Opportunities

GOAL: St. Mary's will address poverty access inequities through offering programs, activites and services free to the community.

Action Plan: Healthy Lifestyle Programs

STRATEGY 1: Provide free programming and resources that support access to healthy choices for the Saginaw Community.

BACKGROUND:

- **Target Population:** Poor & vulnerable, underserved.
- **How the strategy addresses the social determinants of health, health disparities and challenges of the underserved:** Saginaw County ranks 74th out of 83 Michigan counties for overall health outcomes, including 70th in length of life, and 79th in quality of life. Saginaw County ranks 73rd for overall health factors, including 78th in health behaviors, 70th in physical environment, and 60th in social/economic factors. Many of Saginaw County's communities of color and low-income communities are overwhelmed with harmful attributes that compromise individual and community health. Moreover, all demographic, social, and economic impact factors are higher among residents within the City of Saginaw, where higher rates of poverty are associated with poorer educational outcomes, income levels, employment levels, crime/incarceration, and inadequate access to health care/coverage. Residents who are low-income, minority, or un/underinsured are disproportionately impacted by environmental issues such as pollution, crime, property abandonment, lack of areas to exercise outdoors, and lack of access to healthy foods. Saginaw County's 2015 poverty rate (18.3%) slightly exceeds that of the state (16.7%).
- **Strategy Source:** Chronic Disease PATH is an evidence based program. http://patienteducation.stanford.edu

RESOURCES:

- MSU Extension, Master Gardner Association

COLLABORATION:

- MSU Extension, YMCA, Saginaw County Community Mental Health Authority, Saginaw Downtown Farmers Market, community members

ACTIONS:

1. Find additional volunteer instructors to continue free physical activity classes.
2. Develop curriculum and implement Health Gathering support group classes.
3. Apply for grants if needed to sustain programming.
4. Assess need for additional evidence based programming.
5. Develop new community partnerships.
6. Implement program if need is determined.
7. Offer annual community resources meet and greet for Center of Hope community.

ANTICIPATED IMPACT:

STRATEGY 1: Provide free programming and resources that support access to healthy choices for the Saginaw Community.
Short term I. Additional instructors have been secured to continue physical activity classes. II. Biweekly Healthy Gathering classes have been implemented. **Medium Term** III. Need for additional programming and/or funding has been assessed. IV. At least 1 new community partnership developed. **Long Term** V. If need was determined additional funding sources have been established, and new programs have been implemented. VI. Meet and Greet event hosted at the Center of Hope.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
			Ascension: Population Health/ Fee for Value focused on Optimal Patient Outcomes, Enhanced Patient & Provider Experience, and Lower Cost
			HP 2020: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

Prioritized Need 4: Access to Health Care and Utilization of Services

GOAL: Increase access to affordable health care, health insurance and improve utilization and quality of health services delivered to Veterans, uninsured, underserved, and vulnerable populations

Action Plan: Veterans Choice

STRATEGY 1: Position Ascension as a partner in supporting Veterans Affairs (VA) programs to improve services to Veterans via the Veterans Choice Program that are aligned with Population Health care delivery and Triple Aim Outcomes – better health, improved patient experience and reduced cost.

BACKGROUND:

- **Target Population:** Any veteran is covered if he or she meets the eligibility requirements which include: lives more than 40 miles from a VA facility; or unable to get a VA appointment within 30 days of the preferred date, or within 30 days of the date determined medically necessary by their physician; or lack of available specialists; and obtains VA and benefit approval prior to the visit.
- **How the strategy addresses the social determinants of health, health disparities and challenges of the underserved:** Many Saginaw County residents have expressed that the need for quality, affordable health care is the most important issues that should be addressed in the community. There are 641,000 veterans in the state of Michigan, of the Veterans who reside in Michigan, almost half (327,000) are age 65 and older. Michigan ranks 47th out of 53 states and territories for average dollars spent on Veterans. There is a slow and difficult enrollment process for services and significant service gaps as the number of Veterans in the state continues to grow.
- **Strategy Source:** Veterans Access, Choice and Accountability Act of 2014 established a $10 billion fund to pay for healthcare services to Veterans by private healthcare providers. Covers primary care, inpatient and outpatient specialty care, and mental healthcare for eligible Veterans outside the VA.

RESOURCES:

- Ascension coordination of Veterans Choice at the national level that translates into local implementation (marketing, veteran enrollment/engagement process, patient navigation, data collection/sharing)

COLLABORATION:

- Ascension, Department of Veterans Affairs, PHO, AMG, Michigan Department of Military and Veterans Affairs, Michigan Veterans Affairs Agency, Saginaw Department of Veterans Services.

ACTIONS:

1. Align with Ascension providers nationwide to obtain authorization to provide primary care, inpatient and outpatient specialty care, and mental health care for eligible veterans outside of the VA
2. Establish a local Veteran Navigator who can assist Veterans and their families to identify a physician and set medical appointments

STRATEGY 1: Position Ascension as a partner in supporting Veterans Affairs (VA) programs to improve services to Veterans via the Veterans Choice Program that are aligned with Population Health care delivery and Triple Aim Outcomes – better health, improved patient experience and reduced cost.
3. Launch local marketing campaign with national communications messaging aimed at Veterans and families to clarify available services, where services can be accessed, and the enrollment process. 4. Post enrollment process on website 5. Implement the enrollment and navigation process
ANTICIPATED IMPACT: **Short Term** I. SMOM is authorized as the regional provider for the Veterans Choice Program II. Veterans Choice enrollment process is active via website III. Veteran navigation services are established IV. Veterans Choice marketing campaign launched **Medium Term** V. Increased access to care/number of enrolled Veterans VI. Decrease wait times for Veterans to receive services VII. Improved patient management of Veterans with specific disease states VIII. Increased security related to health information exchange between providers **Long Term** IX. Clinical pathways are established with VA (SMOM as regional provider for Veterans) X. Increased patient satisfaction XI. Decreased cost XII. Increased ranking for MI on money spent on Veterans XIII. Coordinated & protected patient information

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
	Genesee County/Flint Community Health Needs Assessment – Greater Flint Health Coalition		**Veterans Access, Choice and Accountability Act of 2014:** Established a $10 billion fund to pay for healthcare services to veterans by private healthcare providers. Covers primary care, inpatient and outpatient specialty care, and mental healthcare for eligible veterans outside of the VA **Ascension:** Population Health/ Fee for Value focused on Optimal Patient Outcomes, Enhanced Patient & Provider Experience, and Lower Cost;

Prioritized Need 4: Access to Health Care and Utilization of Services

GOAL: Develop and implement an evidence-based standard of care for the aging/elderly population in Genesee County that improves health outcomes, enhances patient & provider experience and lowers cost.

Action Plan: Advance Care Planning (ACP)

STRATEGY 1: Develop and Implement Advance Care Planning (ACP) and Advance Directives (AD) for Saginaw County residents and physicians.

BACKGROUND INFORMATION:

- **Target population:** Saginaw County Residents; AMG Staff & patients; PHO Staff & patients; SMOM staff & patients
- **How the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Advance Directives ensure that end-of-life services are delivered according to the wishes of the patient. The County-wide ACP program covers all Saginaw County residents including underserved, low literacy, etc.
- **Strategy source:** Respecting Choices (RC) is an internationally recognized, evidence-based advance care planning (ACP) model of care. Respecting Choices helps to achieve the Triple Aim for patients who use the most health services and need the most support. http://www.gundersenhealth.org/respecting-choices

RESOURCES:

- ACP Facilitators; Existing program materials

COLLABORATION:

- Great Lakes Health Connect (GLHC) , AMG, PHO

ACTIONS:

1. Create Saginaw County ACP Task Force.
2. Develop project plan to implement Respecting Choices model in Saginaw County.
3. Train ACP facilitators.
4. Implement the ACP facilitation model at pilot sites.
5. Provide front line clinical staff with information/education about: 1) ACP resources and how to introduce them to patients; & 2) How to access ACP information from Great Lakes Health Connect (GLHC)
6. Conduct ACP/AD awareness “Lunch & Learns” for appropriate audience.

ANTICIPATED IMPACT:

Short term

I. ACP task force established with consistent meetings.

Medium Term

II. ACP facilitators are trained.

III. ACP Respecting Choice model implemented at pilot sites.

Long term

IV. Front line staff educated.

V. At least 1 Lunch and Learn session for ACP completed.

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
			HP 2020: Access: Improve access to comprehensive, quality health care services; **Older Adults** Improve the health, function, and quality of life of older adults
			Ascension: Population Health/ Fee for Value focused on Optimal Patient Outcomes, Enhanced Patient & Provider Experience, and Lower Cost