Region 6
Anchor: University Health System

RHP Lead Contact:
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President and CEO
University Health System
4502 Medical Dr.
San Antonio, TX 78229
(210) 358-2000
George.Hernandez@uhs-sa.com
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## Section I. RHP Organization

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<th>RHP Participation Type</th>
<th>Texas Provider Identifier (TPI)</th>
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<td>17460021649501</td>
<td>Non-State Owned Public</td>
<td>University Health System</td>
<td>Ted Day Vice President Strategic Planning and Business Development</td>
<td>4502 Medical Dr. San Antonio, TX 78229 (210) 358-8189 <a href="mailto:Ted.Day@uhs-sa.com">Ted.Day@uhs-sa.com</a></td>
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<td>Academic Health Science Center</td>
<td>085144601</td>
<td>17415860315000</td>
<td>State-Owned</td>
<td>University of Texas Health Science Center at San Antonio (UTHSCSA)</td>
<td>Allen Sygman</td>
<td>7703 Floyd Curl Drive San Antonio, Texas 78229 (210) 562-5675 <a href="mailto:sygman@uthscsa.edu">sygman@uthscsa.edu</a></td>
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<td>Hospital District</td>
<td>136141205</td>
<td>17460021649501</td>
<td>Non-State Owned Public</td>
<td>University Hospital</td>
<td>Peggy Deming CFO</td>
<td>4502 Medical Dr. San Antonio, TX 78229 (210) 358-2101 <a href="mailto:Peggy.Deming@uhs-sa.com">Peggy.Deming@uhs-sa.com</a></td>
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<tr>
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<td>12716130781000</td>
<td>Non-State Owned Public</td>
<td>Dimmit Regional Hospital District</td>
<td>Matt Kempton</td>
<td>704 Hospital Drive Carrizo Springs, TX 78834 (830) 278-6251 ex. 1617 <a href="mailto:M.kempton@umhtx.org">M.kempton@umhtx.org</a></td>
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<td>112688002</td>
<td>17414612204000</td>
<td>Non-State Owned Public</td>
<td>Frio Regional Hospital</td>
<td>Michael S. Thompson CEO</td>
<td>200 S. IH 35 Pearsall, TX 78061 (830) 334-3617 x 103 <a href="mailto:michael.thompson@trhta.net">michael.thompson@trhta.net</a></td>
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<tr>
<td>Hospital District</td>
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<td>138411709</td>
<td>17413860531000</td>
<td>Penny Wallace</td>
<td>CFO</td>
<td>1215 E Court Seguin, TX 78155 (830) 401-7220</td>
<td><a href="mailto:pkwallace@grmedcenter.com">pkwallace@grmedcenter.com</a></td>
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<tr>
<td>212140201</td>
<td>12704924344000</td>
<td>Kevin Frosch</td>
<td>CFO</td>
<td>3100 Avenue E Hondo, TX 78861 (830) 426-7898</td>
<td><a href="mailto:kevin.frosch@medinahospital.net">kevin.frosch@medinahospital.net</a></td>
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<tr>
<td>121782003</td>
<td>17416031205000</td>
<td>Matt Kempton</td>
<td>CEO</td>
<td>1025 Garner Field Road Uvalde, TX 78801 (830) 278-6251 ex. 1617</td>
<td><a href="mailto:M.kempton@umhtx.org">M.kempton@umhtx.org</a></td>
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<tr>
<td>119877204</td>
<td>17429415981501</td>
<td>Marc Strode</td>
<td>CEO</td>
<td>801 North Bedell Ave Del Rio, TX 78840 (830) 703-1749 <a href="mailto:marc.strode@vvrmc.org">marc.strode@vvrmc.org</a></td>
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<tr>
<td>135151206</td>
<td>17420197364501</td>
<td>Jerome Brooks</td>
<td>CEO</td>
<td>499 10th Street Floresville, TX 78114 (830) 393-1303 <a href="mailto:jbrooks@connallymmc.org">jbrooks@connallymmc.org</a></td>
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<tr>
<td>NA</td>
<td>14611605537000</td>
<td>Mark Jones</td>
<td>Representative</td>
<td>PO Box 812 Fredericksburg, TX 78624 (830) 990-1777 <a href="mailto:mjones@hillcountrymemorial.org">mjones@hillcountrymemorial.org</a></td>
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<tr>
<td>138706004</td>
<td>NA</td>
<td>Olga Rodriguez</td>
<td>State-Owned Public</td>
<td>San Antonio State Hospital 1100 West 49th Street Austin, Texas 78714 (512) 776-7181 <a href="mailto:Olga.Rodriguez@dshs.state.tx.us">Olga.Rodriguez@dshs.state.tx.us</a></td>
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<td>133257904</td>
<td>N/A</td>
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<td>State-Owned Public</td>
<td>Texas Center for Infectious Disease 1100 West 49th Street Austin, Texas 78714 (512) 776-7181 <a href="mailto:Olga.Rodriguez@dshs.state.tx.us">Olga.Rodriguez@dshs.state.tx.us</a></td>
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<td>137251808</td>
<td>17415906597001</td>
<td>Cynthia A. Martinez</td>
<td>Director of Operations Business Support</td>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services 3031 IH10 West San Antonio, TX 78201 (210) 731-1300 ext. 435 <a href="mailto:camartinez@chcsbc.org">camartinez@chcsbc.org</a></td>
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<td>1268443-05</td>
<td>17427953322000</td>
<td>Andrea Richardson</td>
<td>Bluebonnet</td>
<td>1009 N. Georgetown Street</td>
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<td>Mental Health Center</td>
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<td>Trails Community Services</td>
<td>Executive Director</td>
<td>Round Rock, TX 78664</td>
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<tr>
<td>Community Mental Health Center</td>
<td>Non-State Owned Public</td>
<td>Community Services</td>
<td>Emma C. Garcia</td>
<td>(512) 244-8305</td>
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<td>Community Mental Health Center</td>
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<td>Community Services</td>
<td>David Weden</td>
<td>P. O. Box 725</td>
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<td>Michael S.</td>
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**Performing Providers**

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<tr>
<th>Physician Practice Plan Affiliated with an Academic Health Science Center</th>
<th>State-Owned</th>
<th>University of Texas Health Science Center at San Antonio</th>
<th>Allen Sygman</th>
<th>7703 Floyd Curl Drive</th>
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<td>Christann Vasquez</td>
<td>4502 Medical Dr.</td>
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<td>Public Hospital</td>
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<td>Matt Kempton</td>
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<tr>
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<td>Frio Regional</td>
<td>Michael S.</td>
<td>200 S. IH 35</td>
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<tr>
<td>Owner</td>
<td>Hospital</td>
<td>CEO</td>
<td>Address</td>
<td>Phone</td>
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<td>Guadalupe Regional Medical Center</td>
<td>Penny Wallace CEO</td>
<td>1215 E Court Seguin, TX 78155 (830) 401-7220 <a href="mailto:pkwallace@grmedcenter.com">pkwallace@grmedcenter.com</a></td>
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<tr>
<td>Owned Public</td>
<td>Non-State Owned Public</td>
<td>Medina Regional Hospital</td>
<td>Kevin Frosch CFO</td>
<td>3100 Avenue E Hondo, TX 78861 (830) 426-7898 <a href="mailto:kevin.frosch@medinahospital.net">kevin.frosch@medinahospital.net</a></td>
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<td>Uvalde Memorial Hospital</td>
<td>Matt Kempton</td>
<td>1025 Garner Field Road Uvalde, TX 78801 (830) 278-6251 ex. 1617 <a href="mailto:M.kempton@umhtx.org">M.kempton@umhtx.org</a></td>
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<td>Val Verde Regional Medical Center</td>
<td>Marc Strode CEO</td>
<td>801 North Bedell Ave Del Rio, TX 78840 (830) 703-1749 <a href="mailto:marc.strode@vvrmc.org">marc.strode@vvrmc.org</a></td>
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<tr>
<td>Owned Public</td>
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<td>Connally Memorial Medical Center</td>
<td>Jerome Brooks CEO</td>
<td>499 10th Street Floresville, TX 78114 (830) 393-1303 <a href="mailto:jbrooks@connallymmc.org">jbrooks@connallymmc.org</a></td>
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<td>Texas Center for Infectious Disease</td>
<td>Olga Rodriguez</td>
<td>1100 West 49th Street Austin, Texas 78714 (512) 776-7181 <a href="mailto:Olga.Rodriguez@dshs.state.tx.us">Olga.Rodriguez@dshs.state.tx.us</a></td>
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<tr>
<td>Owned Public</td>
<td>Non-State Owned Public</td>
<td>The Bexar County Board of Trustees for Mental Health Mental Retardation Services, d/b/a The Center For Health Care Services</td>
<td>Cynthia A. Martinez Director of Operations Business Support</td>
<td>3031 IH10 West San Antonio, TX 78201 (210) 731-1300 ext. 435 <a href="mailto:camartinez@chcsbc.org">camartinez@chcsbc.org</a></td>
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<td>Owned Public</td>
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<td>Bluebonnet Trails Community Services</td>
<td>Andrea Richardson Executive Director</td>
<td>1009 N. Georgetown Street Round Rock, TX 78664 (512) 244-8305 <a href="mailto:andrea.richardson@bbtrails.org">andrea.richardson@bbtrails.org</a></td>
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<td>819 Water Street, Suite 300 Kerrville, TX 78028 830-258-5428 <a href="mailto:dweden@hillcountry.org">dweden@hillcountry.org</a></td>
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<td>111 Dallas Street San Antonio, TX 78205 (210) 297-7606 <a href="mailto:Linda.kirks@baptisthealthsystem.com">Linda.kirks@baptisthealthsystem.com</a></td>
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<td>8535 Tom Slick Drive San Antonio, TX 78229 (210) 582-6442 <a href="mailto:helterbrandr@claritycgc.org">helterbrandr@claritycgc.org</a></td>
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<td>333 N. Santa Rosa St. San Antonio, TX 78207 (210) 704-4800 <a href="mailto:patrick.carrier@christushealth.org">patrick.carrier@christushealth.org</a></td>
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<td>333 N. Santa Rosa St. San Antonio, TX 78207 (210) 704-4800 <a href="mailto:patrick.carrier@christushealth.org">patrick.carrier@christushealth.org</a></td>
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<th>Methodist Healthcare System (Methodist Hospital)</th>
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<td>8109 Fredericksburg Road San Antonio, Texas 78229 210-575-0232 <a href="mailto:Jaime.Wesolowski@MHSHealth.com">Jaime.Wesolowski@MHSHealth.com</a></td>
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<td>414 Navarro Street, Suite 600 San Antonio, TX 78205 (210) 579-3252 <a href="mailto:aarel@nixhealth.com">aarel@nixhealth.com</a></td>
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<td>551 Hill Country Drive Kerrville, TX 78028 (830) 258-6389 t <a href="mailto:Davis@petersonrmc.com">Davis@petersonrmc.com</a></td>
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<td>PO Box 835 1020 State Hwy 16 South Fredericksburg, TX 78624</td>
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</table>
| Private Hospital          | 136491104 | 16217955729001 | Private | Southwest General Hospital | Sarah Humme | 7400 Barlite Blvd  
|                          |          |                |         |                          |             | San Antonio, TX 78224  
|                          |          |                |         |                          |             | (210) 921-3572  
|                          |          |                |         |                          |             | shumme@iasishealthcare.com |
| Local Health Department  | 082426001 | 17460020708001 | Non-State Owned Public | San Antonio Metropolitan Health District | Christine Rutherford-Stuart Assistant Director | 332 W. Commerce  
|                          |          |                |         |                          |             | San Antonio, TX 78205  
|                          |          |                |         |                          |             | (210) 207-8896  
|                          |          |                |         |                          |             | Christine.rutherford-stuart@sanantonio.gov |
| UC-Only Hospitals        |          |                |         |                          |             | 1100 West 49th Street  
| Public Hospital          | 138706004 | NA | State-Owned Public | San Antonio State Hospital | Olga Rodriguez | Austin, TX 78714  
|                          |          |                |         |                          |             | (512) 776-7181  
|                          |          |                |         |                          |             | Olga.rodriguez@dshs.state.tx.us |
| Private Hospital         | 121780403 | 17430118400005 | Private | South Texas Regional Medical Center | Conner Hickey | 1905 Hwy 97 East  
|                          |          |                |         |                          |             | Jourdanton, TX 78026  
|                          |          |                |         |                          |             | (830) 399-9466  
|                          |          |                |         |                          |             | Conner_hickey@chs.net |
| Other Stakeholders       |          |                |         |                          |             | 8700 Tesoro, Ste. 700  
| Association             |          |                |         |                          | Martha Spinks, PhD Director | San Antonio, TX 78217  
| Medical Society         |          |                |         |                          |             | (210) 382-8156  
|                          |          |                |         |                          |             | mspinks@aacog.com |
| FQHC                    |          |                |         |                          | Ernesto Gomez, PhD President and CEO | 3750 Commercial Ave.  
|                          |          |                |         |                          |             | San Antonio, TX 78221  
|                          |          |                |         |                          |             | (210) 334-3704  
|                          |          |                |         |                          |             | egomez.cdb@tachc.org |
| FQHC                    |          |                |         |                          | Paul M. Nguyen, MHA President and CEO | 3066 E. Commerce St.  
|                          |          |                |         |                          |             | San Antonio, TX 78220  
|                          |          |                |         |                          |             | Phone: (210) 233-7070  
|                          |          |                |         |                          |             | pnguyen@CommuniCareSa.org |
| FQHC                    |          |                |         |                          | Carlos E. Moreno, MD MBA, CEO | 308 Cesar Chavez  
|                          |          |                |         |                          |             | Crystal City, TX 78839  
|                          |          |                |         |                          |             | (830) 374-2301  
|                          |          |                |         |                          |             | carlosm@vidaysalud.org |
| FQHC                    |          |                |         |                          | Rachel Gonzales-Hanson CEO | 908 S. Evans St. Bldg. A  
|                          |          |                |         |                          |             | Uvalde, TX  
|                          |          |                |         |                          |             | (830) 278-5604  
<p>|                          |          |                |         |                          |             | <a href="mailto:raghanson.chdi@tachc.org">raghanson.chdi@tachc.org</a> |</p>
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</tr>
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<tbody>
<tr>
<td>FQHC</td>
<td>United Medical Centers</td>
<td>George Kypuros CEO</td>
<td>913 S. Main St. Del Rio, TX 78840 <a href="mailto:gkypuros.umc@tachc.org">gkypuros.umc@tachc.org</a></td>
</tr>
<tr>
<td>Provider</td>
<td>ChildSafe</td>
<td>Kim Abernethy, CEO</td>
<td>7130 W. US Hwy 90 San Antonio, TX 78227 (210) 675-9000 <a href="mailto:kima@childsafesa.org">kima@childsafesa.org</a></td>
</tr>
<tr>
<td>City Government</td>
<td>City of Del Rio</td>
<td>Robert Eads City Manager</td>
<td>109 W. Broadway Del Rio, TX 78840 (830) 774-8558 <a href="mailto:reads@cityofdelrio.com">reads@cityofdelrio.com</a></td>
</tr>
<tr>
<td>FQHC</td>
<td>Community Health Centers of South Central Texas</td>
<td>Henry Salas CEO</td>
<td>PO Box 1890 Gonzales, TX 78629 (830) 672-6511 <a href="mailto:salash.gonzales@tach.org">salash.gonzales@tach.org</a></td>
</tr>
<tr>
<td>County Government</td>
<td>Bexar County</td>
<td>Nelson Wolff County Judge</td>
<td>101 W. Nueva, 10th Floor San Antonio, TX (210) 335-2626 <a href="mailto:nwolff@co.bexar.tx.us">nwolff@co.bexar.tx.us</a></td>
</tr>
<tr>
<td>State Government Agency</td>
<td>DSHS Region 8</td>
<td>Lillian Ringsdorf, MD, MPH Interim Regional Medical Director</td>
<td>7430 Louis Pasteur San Antonio, TX 78229 (210) 949-2000 <a href="mailto:sandraG.delgado@dshs.state.tx.us">sandraG.delgado@dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Task Force</td>
<td>Guadalupe County Mental Health Task Force</td>
<td>Elizabeth Murray-Kolb County Attorney</td>
<td>211 W Court Street, Suite 362 Seguin TX <a href="mailto:emk@county.guadalupe.tx.us">emk@county.guadalupe.tx.us</a></td>
</tr>
<tr>
<td>County Government</td>
<td>Kerr County Indigent Care</td>
<td>Rosa Lavender County indigent program supervisor</td>
<td>County Courthouse, Suite CB 102,700 Main Street Kerrville, TX 78028 (830) 792-2297 <a href="mailto:rlavendar@co.kerr.tx.us">rlavendar@co.kerr.tx.us</a></td>
</tr>
<tr>
<td>Association</td>
<td>The Health Collaborative</td>
<td>Elizabeth de la Fuentes Executive Director</td>
<td>1002 N. Flores San Antonio, TX (210) 481-2573 <a href="mailto:edela.fuentes@healthcollaborative.net">edela.fuentes@healthcollaborative.net</a></td>
</tr>
</tbody>
</table>
Section II. Executive Overview of RHP Plan

Regional Healthcare Partnership (RHP) 6 is honored to participate in the Texas Healthcare Transformation and Quality Improvement Program. The 20 counties, anchored by University Health System, are committed to working together to make significant progress over the next five years toward the \textit{triple aim goals of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways}. RHP 6 also strives to leverage local and federal waiver financing to:

- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth
- Improve and prepare the health care infrastructure to serve a newly insured population

RHP 6 includes the following counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala. This RHP represents nine percent of the Texas population and covers more than 24,000 square miles. The majority of RHP 6 residents are Hispanic (54%). Twenty percent of the RHP 6 population did not complete high school, and 16% live below the poverty line. The per capita income is $35,989. Twenty-four percent of residents lack health coverage.
Each county varies in terms of its demographics, socioeconomics, and current health care infrastructure, but nearly every county in RHP 6 is designated as a Health Provider Shortage Area (HPSA) for primary care mental health and/or dental care. As a result, the counties within RHP 6 face similar community needs and health challenges.

- RHP 6 seeks to improve quality and patient satisfaction.
- A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.
- Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.
- There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.
- Lack of interconceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.
- High rates of communicable disease and potential for vaccine preventable diseases due to low vaccine coverage levels in the community.

The vast majority of health care infrastructure is located in Bexar County, home to over 73% of RHP 6 residents. The Bexar County Hospital District, dba University Health System, is the primary safety-net hospital. University Health System has a long history of partnering with private hospitals, both non-profit and for-profit, to meet the needs of Bexar County and south Texas residents. Major hospital partners in Bexar County include CHRISTUS Santa Rosa Health System, Children’s Hospital of San Antonio, Methodist Healthcare, Baptist Healthcare System, Nix Health, Clarity Child Guidance Center, and Southwest General Hospital. Bexar County is also home to the University of Texas Health Science Center at San Antonio (UTHSCSA), which provides training to future doctors, nurses, dentists and other health care providers. The San Antonio Metropolitan Health District is a full service city-county health district which provides leadership and services for San Antonio and Bexar County to prevent illness and injury, promote healthy behaviors, and protect against health hazards.

In the surrounding areas, six hospital districts provide services through their hospitals, which include: Dimmit County Memorial Hospital, Frio Regional Hospital, Guadalupe Regional Medical Center, Medina Regional Hospital, Uvalde Memorial Hospital, and Val Verde County Regional Medical Center. Gillespie County recently established a new hospital authority.

Hill Country Memorial Hospital and Peterson Regional Medical Center are private/non-profit hospitals which serve residents in Gillespie and Kerr Counties, respectively. The following counties do not have hospitals: Bandera, Edwards, Kendall, Kinney, LaSalle, McMullen, Real, and Zavala.
Community Mental Health Centers (CMHCs) are an important part of the regional partnership. Lack of access to mental and behavioral health services has been identified as a critical issue within RHP 6 and the state. Four organizations are actively partnering with hospitals and other entities in unprecedented ways to help improve the delivery and quality of health care in RHP 6. These entities include Bluebonnet Trails Community Services, Camino Real Community Center, Center for Health Care Services, and Hill Country Mental Health and Development Disabilities Centers.

Furthermore, these entities have partnered with local health departments, Federally Qualified Health Centers, elected county officials, community organizations, and other stakeholders to understand community needs, identify new sources of local funding, and ensure investments are made in a collaborative manner.

The 120 Delivery System Reform Incentive Program (DSRIP) projects proposed in this plan address the needs of the broader community. Projects span the breadth of opportunities presented in the RHP Planning Protocol. Projects include expanding medical homes and primary care, increasing access to specialists, implementing technology to perform telemedicine and manage patient registries, and numerous other initiatives. The projects differ in size, scope, and targeted population, but each is geared to achieve specific outcome measures and population-focused improvements. Together, these efforts will enable RHP 6 to achieve the goals of the Triple Aim – improving the health of a population and patients’ experience of care while lowering the associated cost of that care.

### Summary of Categories 1-2 Projects

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Brief Project Description</th>
<th>Related Category 3 Outcome Measure(s)</th>
<th>Estimated Incentive Amount (DSRIP) for DYs 2-5</th>
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</thead>
<tbody>
<tr>
<td><strong>Category 1: Infrastructure Development</strong></td>
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<tr>
<td>159156201.1.1 – PASS 1</td>
<td>1.1.1 Establish more primary care clinics: Expand primary care capacity</td>
<td>159156201.3.1 3.IT-1.10 Diabetes care: HbA1c poor control (&gt;9%) NQF 0059</td>
<td>$11,044,444</td>
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<tr>
<td></td>
<td>Baptist Health System</td>
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<td></td>
<td>TPI: 159156201</td>
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<table>
<thead>
<tr>
<th>TPI: 159156201.1.2 – PASS 1</th>
<th>1.9.2 Improve access to specialty care: Expand specialty care capacity</th>
<th>Expand specialty care capacity by adding new specialty care sites and/or increasing provider hours at existing sites.</th>
<th>159156201.3.2 3.IT-3.2 Congestive Heart Failure 30 day readmission rate $9,881,871</th>
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<tbody>
<tr>
<td>TPI: 159156201</td>
<td>Baptist Health System</td>
<td></td>
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<tr>
<td>TPI: 159156201.1.3 – PASS 1</td>
<td>1.10.1 Enhance improvement capacity within people</td>
<td>Expand existing process improvement programs by training additional staff, improved technology, increase scope and number of projects and enhance PT methods and workforce culture understanding.</td>
<td>159156201.3.4 3.IT-3.2 Congestive Heart Failure 30 day readmission rate $9,300,584</td>
</tr>
<tr>
<td>TPI: 159156201</td>
<td>Baptist Health System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TPI Pending).1.1 – PASS 1</td>
<td>1.9.2 Improve access to specialty care: Pediatric Subspecialty Expansion</td>
<td>Improve access to subspecialty care by establishing practices and creating clinics and other sites of services for children with subspecialty healthcare needs.</td>
<td>(TPI Pending).3.1 3.IT-9.2 ED Appropriate Utilization $9,176,023</td>
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<tr>
<td>TPI: 020844903</td>
<td>Children's Hospital of San Antonio</td>
<td></td>
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<tr>
<td>(TPI Pending).1.2 – PASS 1</td>
<td>1.1.1 Establish more primary care clinics: Primary Care Expansion Program</td>
<td>Develop a geographically dispersed network of pediatric primary care clinics throughout Bexar County to enhance access points, increase available appointment times, and promote patient awareness.</td>
<td>(TPI Pending).3.2 3.IT-9.2 ED Appropriate Utilization $10,587,719</td>
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<tr>
<td>TPI: 020844903</td>
<td>Children's Hospital of San Antonio</td>
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<tr>
<td>TPI: 020844901</td>
<td>Expand primary care capacity to an underserved area of Bexar County through the expansion of clinic space and the addition of four primary care providers.</td>
<td>020844901.3.1</td>
<td>3.IT-9.2</td>
</tr>
<tr>
<td>TPI: 112742503</td>
<td>Provide regional psychiatric services to children ages 3-17 in a setting where a continuum of care is available, to effectively divert patients from local ER settings into the appropriate care level.</td>
<td>112742503.3.1</td>
<td>3.IT-2.13</td>
</tr>
<tr>
<td>TPI: 135151206</td>
<td>Establish hospital owned and operated specialty clinics for targeted specialty care services based on community need.</td>
<td>135151206.3.1</td>
<td>3.IT-1.6</td>
</tr>
<tr>
<td>TPI: 135151206</td>
<td>Establish additional hospital owned and operated primary care clinics. Additional primary care clinics will provide care for unassigned patients and will coordinate care with other medical providers, including hospital emergency department and specialty physicians.</td>
<td>135151206.3.2</td>
<td>3.IT-6.1</td>
</tr>
<tr>
<td>TPI: 217884001</td>
<td>Expand specialty care capacity to meet the needs of its growing rural population.</td>
<td>112690603.3.1</td>
<td>3.IT-6.1</td>
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<tr>
<td>TPI</td>
<td>Description</td>
<td>Plan</td>
<td>Resource</td>
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<td>112690603.1.2</td>
<td>PASS 2</td>
<td>1.6.2 – Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.</td>
<td>Dimmit Regional Hospital</td>
</tr>
<tr>
<td>112688002.1.1</td>
<td>PASS 1</td>
<td>1.1.2 Expand Primary Care Capacity</td>
<td>Frio Regional Hospital</td>
</tr>
<tr>
<td>112688002.1.2</td>
<td>PASS 2</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
<td>Frio Regional Hospital</td>
</tr>
<tr>
<td>TPI: 138411709</td>
<td>Provide space to the Christian Free Clinic and augment its current structure with staff and resources to expand care to patients without insurance.</td>
<td>138411709.3.1</td>
<td>3.IT-1.10 Diabetes care: HbA1c poor control (&gt;9%)</td>
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<td><strong>138411709.1.1</strong> – PASS 1</td>
<td>1.1.2 Expand Existing Primary Care Capacity - GRMC Guadalupe Regional Medical Center</td>
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<tr>
<td><strong>133260309.1.1</strong> – PASS 1</td>
<td>1.1.2 Expand existing primary care capacity: a) expand primary care clinic space; b) expand primary care clinic hours; and c) expand primary care clinic staffing. Medina Regional Hospital</td>
<td></td>
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<tr>
<td><strong>133260309.1.2</strong> – PASS 2</td>
<td>1.10.1 Enhance improvement capacity within people – Medina Healthcare System Medina Regional Hospital</td>
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<tr>
<td><strong>133260309.1.3</strong></td>
<td>Expand primary care capacity by adding healthcare providers and increasing the hours of Medina Regional Hospital (MRH) health clinics, as well as some expansion of space.</td>
<td>133260309.3.1</td>
<td>3.IT-1.12 Diabetes care: retinal eye exam</td>
</tr>
<tr>
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<td>133260309.3.2</td>
<td>3.IT-1.13 Diabetes care: foot exam</td>
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<td>133260309.3.3</td>
<td>3.IT-1.14 Diabetes care: microalbumin / Nephropathy</td>
</tr>
<tr>
<td></td>
<td>Expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct report, drive and measure quality improvement.</td>
<td>133260309.3.4</td>
<td>3.IT-12.1 Primary Care Prevention: Breast cancer screening</td>
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<tr>
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<td>133260309.3.5</td>
<td>3.IT-12.2 Primary Care Prevention: Cervical cancer screening</td>
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<td>133260309.3.6</td>
<td>3.IT-12.4 Primary Care Prevention: Pneumonia vaccination for older adults</td>
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<tr>
<td>TPI</td>
<td>Title</td>
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<td>TPI</td>
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<tr>
<td>094154402.1.1 – PASS 1</td>
<td>1.7.1 Introduce, Expand, or Enhance Telemedicine/Telehealth</td>
<td>Establish Telemedicine/Telehealth Program for area of community need.</td>
<td>094154402.3.1</td>
</tr>
<tr>
<td>094154402.1.2 – PASS 1</td>
<td>1.9.2 Improve access to specialty care</td>
<td>Expand Specialty Care Capacity by locating a freestanding Emergency Department in the Westside of San Antonio.</td>
<td>094154402.3.2</td>
</tr>
<tr>
<td>127294003.1.1 – PASS 2</td>
<td>1.10.2 Enhance improvement capacity through technology</td>
<td>Implement a process using technology to provide actionable data. Provide Organization wide training on the use of that data to drive efficiency, improve quality measure monitoring, increase patient safety, and enhance patient-centered care activities throughout the entire system.</td>
<td>127294003.3.4</td>
</tr>
<tr>
<td>136491104.1.1 – PASS 1</td>
<td>1.9.2 Improve access to specialty care: improve outcomes for diabetic pregnancies.</td>
<td>Develop and implement a Gestational Diabetes program to educate and monitor patients throughout the pregnancy, therefore improving patient outcomes.</td>
<td>136491104.3.1</td>
</tr>
<tr>
<td>136141205.1.1 – PASS 1</td>
<td>1.1.1 Establish more primary care clinics: University Hospital</td>
<td>Partner with a local FQHC to establish and expand clinical and community preventive services via the patient-centered medical home and thereby expand access to care to a rapidly growing section of Bexar County, Texas.</td>
<td>136141205.3.1</td>
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<tr>
<td>136141205.3.2</td>
<td>3.IT-8.5</td>
<td>Frequency of ongoing prenatal care</td>
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| TPI: 136141205 | 136141205.3.3  
| 3.IT-8.2  
Percentage of Low-birth weight births | 136141205.3.4  
3.IT-9.2  
ED appropriate utilization | $19,281,864 |
|---|---|---|
| 136141205.1.2  
1.1.2 - Expand existing primary care capacity: University Hospital expanding capacity  
University Hospital  
TPI: 136141205 | Expand existing primary care clinic space, expand hours of operations at primary care clinic sites and expand the primary care clinic staffing | 136141205.3.5  
3.IT-9.2  
ED appropriate utilization | $19,281,864 |
| 136141205.1.3  
1.3.1- Implement and use chronic disease management registry functionalities  
University Hospital  
TPI: 136141205 | Develop and use a chronic disease management registry specifically targeting the Health System’s Medicaid and uninsured patient population diagnosed with asthma. | 136141205.3.6  
3.IT-2.8  
Diabetes Long Term Complications Admission Rate – PQI3 (Standalone measure) | $16,389,584 |
| 136141205.1.4  
1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: University Hospital Telemedicine Program  
University Hospital  
TPI: 136141205 | Employ telemedicine services to the Medicaid and uninsured pediatric/young adult asthma patient populations in the ambulatory setting. | 136141205.3.7  
3.IT-1.18  
Follow up after hospitalization for mental illness | $19,281,864 |
| 136141205.1.5  
1.9.2 Expand access to specialty care (behavioral health)  
University Hospital  
TPI: 136141205 | Increase access to specialty care by expanding its provider base and having patients receive behavioral health services through its integrated patient-centered medical home. | 136141205.3.8  
3.IT-12.5  
Other USPSTF- Screening for obesity in children and | $16,389,584 |
| University Hospital | adolescents | 136141205.3.9  
| TPI: 136141205 | 3.IT-12.5  
| | Other USPSTF- 
| | Screening for MDD in 
| | adolescents  
| | 136141205.3.10  
| | 3.IT-12.5  
| | Other USPSTF- 
| | Screening/Immunization of MVC-1 in 
| | adolescents |

| 136141205.1.7 – PASS 2 | Strengthen access to culturally 
| 1.4.1 Expand Access to Written and Oral Interpretation Services | competent patient-centered 
| University Hospital | care through strategies that 
| TPI: 136141205 | promote timely oral 
| | interpretation/translation 
| | services, improve the fluid 
| | exchange of health information 
| | between patients and 
| | healthcare professionals and 
| | promote opportunities for 
| | patient to adhere to prescribed 
| | clinical care and treatment 
| | regimens. | 136141205.3.19  
| | 3.IT-6.1  
| | Percent improvement 
| | over baseline of 
| | patient satisfaction 
| | scores | $13,774,267 |

| 136141205.1.8 – PASS 3 | Increase pediatric primary 
| 1.1.2 Expand existing primary care capacity: Patient-centered pediatric care | care (including pediatric urgent 
| University Hospital | care) clinic visit volume and 
| TPI: 136141205 | provide evidence of improved 
| | access for patients seeking 
| | services. Accomplish this 
| | intervention through hiring 
| | more pediatricians and mid- 
| | level providers to enhance 
| | access for pediatric patients. | 136141205.3.25  
| | 3.IT-9.3  
| | Pediatric /young adult asthma emergency 
| | department visits | $15,918,541 |

| 136141205.1.9 – PASS 3 | Development and expand a 
| 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Psychiatric Emergency Services (PES) | psychiatric emergency service with capacity to accommodate voluntary and involuntary patients with mental illness and in acute crisis. It offers an alternative to medical emergency rooms for those patients not requiring emergent/urgent evaluation and stabilization of physical medical conditions. | 136141205.3.26  
| University Hospital | 3.IT-9.2  
<p>| TPI: 136141205 | ED appropriate utilization | $15,918,541 |</p>
<table>
<thead>
<tr>
<th>TPI</th>
<th>Plan</th>
<th>Describe</th>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>136141205.1.10 – PASS 3</td>
<td>1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Intervention Unit (CIU) University Hospital TPI: 136141205</td>
<td>Create a crisis intervention unit that can provide care in a safe environment for those patients who do not require acute care admissions.</td>
<td>136141205.3.27 3.IT-3.8 Behavioral health/substance abuse 30 day readmission rate</td>
<td>$15,918,541</td>
</tr>
<tr>
<td>136141205.1.11 – PASS 3</td>
<td>1.8.6 Increase and expand oral health services University Hospital TPI: 136141205</td>
<td>Establish timely, accessible, integrated, and patient-centered preventive and primary oral health care services for economically vulnerable populations residing in Bexar County, Texas through a partnership between University Health System (UHS) and partner Federally Qualified Health Centers (FQHCs).</td>
<td>136141205.3.28 3.IT-7.8 Chronic disease patients accessing dental services</td>
<td>$4,101,366</td>
</tr>
<tr>
<td>121782003.1.1 – PASS 1</td>
<td>1.2.2 Increase the number of primary care providers and other clinicians/staff: Improving Rural Access to Primary Care Uvalde Memorial Hospital TPI: 121782003</td>
<td>Improve access to primary care within the rural service region through expanding capacity and a community health worker training program.</td>
<td>121782003.3.1 3.IT-3.1 All cause 30 day readmission rate – NQF 1789</td>
<td>$8,320,096</td>
</tr>
<tr>
<td>119877204.1.1 – PASS 1</td>
<td>1.1.1 - Expand primary care capacity – Val Verde County and Del Rio, Texas Val Verde Regional Medical Center TPI: 119877204</td>
<td>Establish additional primary care providers to a medically underserved area along the Rio Grande border.</td>
<td>119877204.3.1 3.IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$4,174,952</td>
</tr>
<tr>
<td>119877204.1.2 – PASS 1</td>
<td>1.9.2 - Expand specialty care capacity for Val Verde County and</td>
<td>Establish additional specialty care providers to a medically underserved area along the</td>
<td>119877204.3.2 3.IT-6.1 Percent improvement</td>
<td>$4,174,952</td>
</tr>
<tr>
<td>Del Rio, TX</td>
<td>Rio Grande border.</td>
<td>over baseline of patient satisfaction scores</td>
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<tr>
<td>Val Verde Regional Medical Center</td>
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<tr>
<td>TPI: 119877204</td>
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<tr>
<th>119877024.1.3 – PASS 2</th>
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<tr>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region – Val Verde County and Del Rio, Texas</td>
</tr>
<tr>
<td>Introduce a robotic telemedicine program for access to specialty care in its rural community in the emergency room and inpatient bedded units.</td>
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<tr>
<td>119877204.3.3</td>
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<tr>
<td>3.IT-6.1</td>
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<tr>
<td>Percent improvement over baseline of patient satisfaction scores</td>
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<tr>
<td>$2,229,516</td>
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<tbody>
<tr>
<td>1.2.2 Increase the number of primary care providers (nurse practitioners and physician assistants) and other clinicians/staff (allied health professionals)</td>
</tr>
<tr>
<td>Increase training of mid-level providers including Nurse Practitioners and Physician assistants in the primary care setting.</td>
</tr>
<tr>
<td>92414401.3.1</td>
</tr>
<tr>
<td>IT-9.2</td>
</tr>
<tr>
<td>ED appropriate utilization</td>
</tr>
<tr>
<td>$7,605,496</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>085144601.1.1 – PASS 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10.1 Enhance Improvement Capacity within people (Improving Inter-professional Team-Based Care for Patient Safety)</td>
</tr>
<tr>
<td>Customize, implement, and evaluate an innovative evidence-based inter-professional team-based care model to achieve high team performance for patient safety in all healthcare practice settings of the Health Science Center.</td>
</tr>
<tr>
<td>085144601.3.1</td>
</tr>
<tr>
<td>3.IT-4.10</td>
</tr>
<tr>
<td>Other outcome improvement target</td>
</tr>
<tr>
<td>$1,793,123</td>
</tr>
<tr>
<td>Project Number</td>
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<tr>
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<tr>
<td>085144601.1.2 - PASS 1</td>
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<tr>
<td>085144601.1.3 - PASS 1</td>
</tr>
<tr>
<td>085144601.1.4 - PASS 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Project Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a quality improvement (QI) data mart for the outpatient management by UT Medicine Clinics, assist with building a parallel data mining resource for all University Health System clinics, and develop a Health Information Exchange (HIE) to ensure seamless exchange of information</td>
<td>085144601.3.2 3.IT-11.1</td>
</tr>
<tr>
<td>Improvement in clinical indicator in identified disparity group</td>
<td>085144601.3.3 3.IT-11.2</td>
</tr>
<tr>
<td>Improvement in disparate health outcomes for target population, including identification of the disparity gap</td>
<td>$8,069,055</td>
</tr>
<tr>
<td>Increase the number of primary care physicians in South Texas by increasing the number of Family Medicine residents in training.</td>
<td>085144601.3.4 3.IT-9.2</td>
</tr>
<tr>
<td>ED appropriate utilization</td>
<td>$6,724,213</td>
</tr>
<tr>
<td>Make the specialty care services of UT Medicine more accessible to non-UT Medicine physicians throughout the South Texas area through the implementation of a web based, HIPAA compliant, referral portal integrated with UT Medicine’s EpicCare electronic health record (EHR) system.</td>
<td>085144601.3.5 3.IT-6.1</td>
</tr>
<tr>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>$3,586,246</td>
</tr>
<tr>
<td>Project Option</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.3.2 “Other” project option:</td>
<td>Populate a Chronic Disease Management Registry Using a Health Information Exchange System which Combines Ambulatory and Hospital Data UTHSCSA TPI: 085144601</td>
</tr>
<tr>
<td>085144601.1.6 – PASS 1</td>
<td>Establish a clinical training program for treatment of Substance Use Disorders 085144601.3.7 3.IT-3.8 Behavioral health / substance abuse 30 day readmission rate</td>
</tr>
<tr>
<td>1.14.2 Other project option:</td>
<td>Expand specialty care capacity through the Sustained Treatment as an Outpatient Priority (STOP) Program UTHSCSA TPI: 085144601</td>
</tr>
<tr>
<td>085144601.1.7 – PASS 1</td>
<td>Increase accessibility to outpatient neurology services 085144601.3.8 3.IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>1.9.2 Improve Access to Specialty Care: Outpatient Neurology Services</td>
<td>Establish a clinical training program for treatment of Neuropsychological Services that will improve access to neuropsychological testing services for patients with epilepsy, stroke, Alzheimer’s disease, brain tumors, and traumatic brain injuries UTHSCSA TPI: 085144601</td>
</tr>
<tr>
<td>085144601.1.10 – PASS 1</td>
<td>Nurse-Managed Clinics: Improving Access, Expanding Clinical Sites, Promoting Interprofessional Education and Evidence-based Practice, Optimizing EHR Use and Financial Sustainability</td>
</tr>
<tr>
<td>TPI: 085144601</td>
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<tr>
<td><strong>085144601.1.11</strong> – PASS 1</td>
<td></td>
</tr>
<tr>
<td>1.1.1 Establish more primary Care Clinics: Primary Care and Behavioral Care Capacity Expansion at UT Medicine San Antonio</td>
<td>Improve care for chronic disease and prevention and enhance behavioral health integration and availability by establishing two new primary clinics.</td>
</tr>
<tr>
<td>UTHSCSA</td>
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<td>TPI: 085144601</td>
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<tr>
<td><strong>085144601.1.12</strong> – PASS 1</td>
<td></td>
</tr>
<tr>
<td>1.8.6 Increase, Expand and Enhance Dental Services</td>
<td>Establish an emergency dental clinic for treating patients presenting with urgent dental conditions including oral infections, abscesses, pain and fractured dental restorations.</td>
</tr>
<tr>
<td>UTHSCSA</td>
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<td>TPI: 085144601</td>
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</tr>
<tr>
<td><strong>085144601.1.13</strong> – PASS 1</td>
<td></td>
</tr>
<tr>
<td>1.8.12 “Other” project option to enhance oral health services: Electronic Health Record</td>
<td>Implement and train the dental school faculty, staff, dental/dental hygiene students and residents in the use of the certified electronic record</td>
</tr>
<tr>
<td>UTHSCSA</td>
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<td>TPI: 085144601</td>
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</tr>
<tr>
<td><strong>085144601.1.15</strong> – PASS 2</td>
<td></td>
</tr>
<tr>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region [Reengineering the Hearing Health Care System in South Texas: A Telehealth Model for Addressing the Unmet Hearing Health Care/Hearing Aid Needs of Adults with Mild to Severe Bilateral Sensorineural Hearing Loss]</td>
<td>Establish an innovative pilot South Texas (Bexar County) Hearing Health Care Delivery Model that incorporates existing and new resources including: Teleaudiology; a new level of support personnel (Teleaudiology Clinical Technicians (TCTs); “Drop-In Hearing Clinics” ; community clinic collaborations; and existing partner audiologists, otolaryngologists and Primary Care Providers (MDs/NPs/PAs) and targets primarily members of the adult hard of hearing population; the majority of whom are not receiving diagnostic/rehabilitative help</td>
</tr>
<tr>
<td>TPI: 085144601.1.16 – PASS 2</td>
<td>Provide ideal cancer healthcare to underserved areas.</td>
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<tr>
<td>1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care</td>
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<tr>
<td>UTHSCSA</td>
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<td>TPI: 085144601</td>
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<tr>
<td>TPI: 085144601.1.17 – PASS 2</td>
<td>Train new oncologists to enhance delivery of cancer care in underserved areas of South Texas.</td>
</tr>
<tr>
<td>1.9.3 Implement other evidence based project to expand specialty care capacity in an innovative manner – Oncology</td>
<td></td>
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<tr>
<td>UTHSCSA</td>
<td></td>
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<tr>
<td>TPI: 085144601</td>
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<tr>
<td>TPI: 085144601.1.18 – PASS 2</td>
<td>Through the addition of a multi-specialty, multi-site pediatric subspecialty clinic UT Medicine has the opportunity to supplement a network of pediatric care partnering with a new academic children’s hospital and a comprehensive network of services.</td>
</tr>
<tr>
<td>1.9.2 Improve Access to Specialty Care (Pediatric Specialty Care Network)</td>
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<tr>
<td>UTHSCSA</td>
<td></td>
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<tr>
<td>TPI: 085144601</td>
<td></td>
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<tr>
<td>TPI: 085144601.1.20 – PASS 2</td>
<td>Implement CG CAHPS to measure patient satisfaction.</td>
</tr>
<tr>
<td>1.10.1 Enhance improvement capacity within people [redesign to improve patient experience]</td>
<td></td>
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<tr>
<td>UTHSCSA</td>
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<tr>
<td>TPI: 085144601</td>
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<td>TPI</td>
<td>Description</td>
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<tr>
<td>085144601.1.23</td>
<td>Improve Access to Specialty Care (Outreach Epilepsy Clinic – Uvalde)</td>
</tr>
<tr>
<td>1268443-05.1.1</td>
<td>Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system. Child Crisis Respite through Therapeutic Foster Care</td>
</tr>
<tr>
<td>1268443-05.1.2</td>
<td>Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Substance Abuse Treatment and Intervention Services</td>
</tr>
<tr>
<td>121990904.1.1</td>
<td>Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization</td>
</tr>
<tr>
<td>121990904.1.2</td>
<td>Enhance service availability (i.e., hours, locations,</td>
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</tbody>
</table>

$2,007,425

$2,395,828

$1,387,058

$6,232,135

$1,664,117

26 ★ RHP 6 Plan ★ March 8, 2013
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>137251808.1.1</td>
<td>- PASS 1</td>
<td>1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Establish a residential crisis and respite center for children with severe emotional disturbance.</td>
</tr>
<tr>
<td>137251808.1.2</td>
<td>- PASS 1</td>
<td>1.12.1 Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based setting in areas of the State where access to care is likely to be limited: Widen the network of neighborhood-based mental health service sites throughout Bexar County.</td>
</tr>
<tr>
<td>137251808.1.3</td>
<td>- PASS 1</td>
<td>1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Establish crisis transitional residential options, up to 32 beds, for adults.</td>
</tr>
<tr>
<td>137251808.1.4</td>
<td>- PASS 1</td>
<td>1.12.2 - Expand the number of community based settings where behavioral health services may be obtained: Establish a centralized, accessible campus from which systems or families can obtain care for children and adolescents (0 to 17 years).</td>
</tr>
<tr>
<td>137251808.3.1</td>
<td>3.IT-5.1</td>
<td>Improved cost savings: demonstrate cost savings in care delivery.</td>
</tr>
<tr>
<td>137251808.3.2</td>
<td>3.IT-9.2</td>
<td>ED appropriate utilization.</td>
</tr>
<tr>
<td>137251808.3.3</td>
<td>3.IT-10.1</td>
<td>Quality of Life.</td>
</tr>
<tr>
<td>137251808.3.4</td>
<td>3.IT-3.8</td>
<td>Behavioral health / substance abuse 30 day readmission rate.</td>
</tr>
<tr>
<td>137251808.3.5</td>
<td>3.IT-10.1</td>
<td>Quality of Life.</td>
</tr>
<tr>
<td>Plan</td>
<td>March 8, 2013</td>
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<tr>
<td>RHP 6 Plan</td>
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</tbody>
</table>

**Category 2: Program Innovation and Redesign**

<table>
<thead>
<tr>
<th>Plan</th>
<th>March 8, 2013</th>
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</thead>
<tbody>
<tr>
<td>159156201.2.1 – PASS 1</td>
<td></td>
</tr>
</tbody>
</table>

2.8.1 Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and  

Using process improvement tools and trained workforce and apply to identify clinical care areas and processes to confirm to current best practices and reduce variation in treatment plans and health outcomes.  

159156201.3.6  
3.IT-3.2  
Congestive Heart Failure 30 day readmission rate  

159156201.3.7  

$9,300,584
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Details</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 RHP 6 Plan</td>
<td>3.10.3.5 Acute Myocardial Infarction 30 day readmission rate</td>
<td>Improve quality access to primary care for the Medicare and Medicaid population in the community by contributing to the expansion of medical homes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.2 - Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients: Patient Centered Medical Home</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>CHISTUS Santa Rosa Health System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>020844901.2.1</td>
<td>PASS 1</td>
<td>2.1.2 - Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients: Patient Centered Medical Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve quality access to primary care for the Medicare and Medicaid population in the community by contributing to the expansion of medical homes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>020844901.2.2</td>
<td>PASS 1</td>
<td>2.12.1 - Develop, implement, and evaluate standardized clinical protocols and evidenced-based care delivery model to improve care transitions: Care Transitions – Nurse Intervention Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create smooth transitions of care from the inpatient to outpatient setting, so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>138411709.2.1</td>
<td>PASS 1</td>
<td>2.12.2- Implement/Expand Care Transitions Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The project would implement improvements in transitioning patients and coordination of care from inpatient to outpatients, post-acute care, and home care settings.</td>
<td></td>
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</tr>
<tr>
<td>138411709.2.2</td>
<td>PASS 2</td>
<td>2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care</td>
<td></td>
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<tr>
<td></td>
<td>Establish a patient navigation system to assist high utilizers of the ED to receive coordinated, timely and appropriate healthcare services.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Establish a patient navigation system to assist high utilizers of the ED to receive coordinated, timely and appropriate healthcare services.</td>
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</tr>
</tbody>
</table>
| TPI: 138411709 | 136430906.2.1 – PASS 1 | 136430906.3.1  
2.7.1, Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Health Screening and Education for the Uninsured  
Hill Country Memorial Hospital  
TPI: 136430906 | 136430906.3.2  
3.IT-12.3  
Colorectal cancer screening (HEDIS 2012)  
136430906.3.3  
3.IT-12.5 Other USPSTF-endorsed screening outcome measures: screening for high blood pressure in adults aged 18 and older | $2,625,518 |
|---|---|---|---|---|
| 136430906.2.1 – PASS 1 | Expand a wellness education and screening program to the uninsured employed residents living in Hill Country Memorial Hospital’s service area. | 136430906.3.1  
2.7.1, Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Health Screening and Education for the Uninsured  
Hill Country Memorial Hospital  
TPI: 136430906 | 136430906.3.2  
3.IT-12.3  
Colorectal cancer screening (HEDIS 2012)  
136430906.3.3  
3.IT-12.5 Other USPSTF-endorsed screening outcome measures: screening for high blood pressure in adults aged 18 and older | $2,625,518 |
| 094154402.2.1 – PASS 1 | 094154402.2.2 – PASS 1 | 094154402.3.1  
2.4.2 Redesign to improve patient experience  
Methodist Healthcare System (Methodist Hospital)  
TPI: 094154402 | 094154402.3.3  
3.IT-6.1  
Percent improvement over baseline of patient satisfaction scores | $9,680,200 |
| 094154402.2.1 – PASS 1 | Redesign to improve patient experience- measure patient experience | 094154402.3.1  
2.4.2 Redesign to improve patient experience  
Methodist Healthcare System (Methodist Hospital)  
TPI: 094154402 | 094154402.3.3  
3.IT-6.1  
Percent improvement over baseline of patient satisfaction scores | $9,680,200 |
| 094154402.2.2 – PASS 1 | 094154402.2.2 – PASS 1 | 094154402.3.1  
2.4.2 Redesign to improve patient experience  
Methodist Healthcare System (Methodist Hospital)  
TPI: 094154402 | 094154402.3.3  
3.IT-6.1  
Percent improvement over baseline of patient satisfaction scores | $9,680,200 |
### 112676501.2.1 – PASS 1

2.1.1 Enhance/Expand Medical Homes: Nix Health Medical Homes

Nix Health Care System

TPI: 297342201

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two new physicians to the market will base their Provider Based Clinic around the Patient Centered Medical Home Model (PCMH).</td>
<td></td>
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</tr>
</tbody>
</table>

### 112676501.2.2 – PASS 1

2.8.1 Design, develop, and implement a program of continuous rapid process improvement that will address issues of safety, quality, and efficiency within the Nix Geriatric Med/Surg Inpatient Population

Nix Health Care System

TPI: 297342201

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similar to the process improvement practices implemented by the NICHE program, Nix will identify evidence based practices that may help improve the safety, quality and efficiency of the geriatric patients during their hospitalization, and work to incorporate these practices into the care these patients receive during their stay and post-discharge.</td>
<td></td>
<td>$9,957,974</td>
</tr>
</tbody>
</table>

### 112676501.3.1

3.IT-12.1

Primary Care Prevention: Breast cancer screening: number of women aged 40 to 69 that have received an annual mammogram during the reporting period

### 112676501.3.2

3.IT-12.3

Primary Care Prevention: Colorectal screening: number of adults aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every ten years

### 112676501.3.3

3.IT-12.4

Primary Care Prevention: Pneumonia vaccination status for older adults: number of adults aged 65 and older that have ever received a pneumonia vaccine

### 112676501.3.4

3.IT-3.1

Potentially Preventable Readmissions: All cause 30 day readmission rate-NQF 178935

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
<th>Cost</th>
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<tbody>
<tr>
<td></td>
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<td>$6,561,424</td>
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<tr>
<td>TPI</td>
<td>Project Title</td>
<td>Description</td>
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</tr>
<tr>
<td>112676501.2.3</td>
<td>Establish a Patient Care Navigation Program</td>
<td>Implement a Patient Navigator Program to help patients and their families navigate the fragmented maze of the healthcare system, including primary care physician offices, specialists, preventive screenings, diagnostic testing, inpatient admissions, payment systems, and community resources.</td>
</tr>
<tr>
<td>127294003.2.1</td>
<td>Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions</td>
<td>Implement a new discharge and care transition process.</td>
</tr>
<tr>
<td>136491104.2.1</td>
<td>Implement an evidence-based health promotion program: develop, implement and evaluate an innovative evidence-based strategy through the use of a mobile cardiovascular screening program</td>
<td>Provide a mobile vascular screening service which will provide non-invasive cardiovascular screenings.</td>
</tr>
<tr>
<td>133257904.2.1</td>
<td>Implement other evidence-based prevention program in an innovative manner: TB Prevention Program</td>
<td>Implement a TB prevention program</td>
</tr>
<tr>
<td>136141205.2.1 – PASS 1</td>
<td>Implement a care transitions program specifically to address the window of time between discharge and either a return EC visit and/or PCP/clinic visit.</td>
<td>136141205.3.11</td>
</tr>
<tr>
<td>136141205.2.2 – PASS 1</td>
<td>Develop and implement a comprehensive patient experience training program.</td>
<td>136141205.3.12</td>
</tr>
<tr>
<td>136141205.2.3 – PASS 1</td>
<td>Implement the Lean methodology to determine the use of materials and human resources, improve value to the patient, distinguish how and why inputs into certain processes translate into value, and find ways to eliminate wasteful components.</td>
<td>136141205.3.13</td>
</tr>
<tr>
<td>136141205.2.4 – PASS 1</td>
<td>Establish and enhance patient navigators consisting of social workers and case managers beyond acute care and within the emergency center and defined ambulatory clinics to support the patients within the region. The project will work as a support network and educational system to aid and facilitate patient activation and empowerment.</td>
<td>136141205.3.15</td>
</tr>
</tbody>
</table>
| 136141205.2.5 – PASS 1 | Provide access to comprehensive supportive care services for patients in Bexar County who are at risk for serious illness and to improve quality of life for patients and families facing serious illness through intensive communication, pain and symptom management, advanced care planning, and coordination of care. | 136141205.3.16  
3.IT-13.1  
Pain assessment  
136141205.3.17  
3.IT-13.2  
Treatment preferences  
136141205.3.18  
3.IT-13.5  
Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss | $16,389,584 |
| 136141205.2.7 – PASS 2 | Implement an innovative community-based intervention model to increase access to clinical preventive services throughout Bexar County, Texas. | 136141205.3.21  
3.IT-12.1  
Breast cancer screening  
136141205.3.22  
3.IT-12.2  
Cervical cancer screening  
136141205.3.23  
3.IT-12.3  
Colorectal cancer screening | $12,052,487 |
| 136141205.2.8 – PASS 2 | Dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease medication management among the patients assigned to that clinic. | 136141205.3.24  
3.IT-2.11  
Ambulatory care sensitive conditions admissions rate | $14,635,162 |
<p>| 136141205.2.9 - PASS 3 | Implement a care transitions program for patients identified | 136141205.3.29 | $15,918,541 |</p>
<table>
<thead>
<tr>
<th>Project ID</th>
<th>Description</th>
<th>Details</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>136141205.2.10</td>
<td><strong>2.12.2 Implement a Care Transitions Project for the CHF Population</strong></td>
<td>University Hospital TPI: 136141205 as having congestive heart failure as a primary or secondary diagnosis. Within the project the target population and existing pre and post acute services will be identified for more comprehensive engagement and protocols will be established to prevent hospitalization and/or readmissions.</td>
<td><strong>$12,052,487</strong></td>
</tr>
<tr>
<td>136141205.3.30</td>
<td><strong>3.IT-3.2 Congestive heart failure 30 day admission rate</strong></td>
<td>This project takes a two prong approach using the evidence-based Chronic Care Model at helping patients manage their diabetes through providing training of their primary care providers to stratify the risk of their condition and recommending appropriate treatment, and allowing the patient to receive all necessary care through their usual place of healthcare.</td>
<td></td>
</tr>
<tr>
<td>Project ID</td>
<td>Status</td>
<td>Objective</td>
<td>TPI:</td>
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<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>092414401.2.2</td>
<td>PASS 2</td>
<td>2.1.1 - Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: Community Medicine Associates</td>
<td>092414401.3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement a Primary Care Home Model concept for CareLink members in Bexar County.</td>
<td>3.IT-9.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ED appropriate utilization</td>
</tr>
<tr>
<td>085144601.2.1</td>
<td>PASS 1</td>
<td>2.7.6 Implement other evidence based Disease Prevention Program in an innovative manner: TEACH (Targeting Environmental Aspects of Children's Health)</td>
<td>085144601.3.18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrate Primary and Behavioral Health Care Services for children diagnosed with lead poisoning and asthma, and children with asthma.</td>
<td>3.IT-9.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pediatrics/Young adult asthma ED visits</td>
</tr>
<tr>
<td>085144601.2.2</td>
<td>PASS 1</td>
<td>2.15.1 Design, implement, and evaluate projects that provide integrated primary and Behavioral health care services: PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD)</td>
<td>085144601.3.19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD) is an integrated mental and physical health program for children with ADHD and related disorders.</td>
<td>3.IT-2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Behavioral health / substance abuse (BH/SA) admission rate</td>
</tr>
<tr>
<td>Project Code</td>
<td>Title</td>
<td>Implementation Details</td>
<td>TPI Code</td>
</tr>
<tr>
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</tr>
<tr>
<td>085144601.2.3</td>
<td>2.13.2 Implement other evidence-based project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner</td>
<td>Expand the Transitional Care Clinic (TCC) to give patients rapid access to a prescriber upon hospital discharge or diversion from emergency departments (ED) and provide gap services and linkage to community services. The TCC also functions as a specialty training program in community psychiatry training residents and nurse practitioners</td>
<td>085144601.3.20</td>
</tr>
<tr>
<td>085144601.2.4</td>
<td>2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Community health worker program to address health and social needs in a vulnerable population</td>
<td>Implement a patient navigator program linked to a primary care safety net clinic to improve diabetes outcomes.</td>
<td>085144601.3.21</td>
</tr>
<tr>
<td>085144601.2.5</td>
<td>2.9.2 Implement other evidence-based project to establish a patient care navigation program in an innovative manner: Expanding chronic care management in a safety net clinic</td>
<td>Implement patient management consistent with the chronic care model (CCM) in a large safety net primary care practice.</td>
<td>085144601.3.22</td>
</tr>
<tr>
<td>Project Number</td>
<td>Status</td>
<td>Description</td>
<td></td>
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<td>----------------</td>
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<td></td>
</tr>
</tbody>
</table>
| 085144601.2.6 – PASS 2 | | 2.13.2 Implement other evidence-based project to provide intervention for a targeted behavioral health population to prevent unnecessary use of services. (Transdermal Alcohol Monitoring Intervention to Reduce Drunk Driving, Lower Incarceration Costs, and Prevent Recidivism)  
UTHSCSA  
TPI: 085144601 |
| 1268443-05.2.1 – PASS 1 | | 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutional health care: Patient Navigator for Persons with Chronic Mental Illnesses  
Bluebonnet Trails Community Services  
TPI: 126844305 |
| 1268443-05.2.2 – PASS 2 | | 2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Transitional housing with behavioral supports  
Bluebonnet Trails Community Services  
TPI: 126844305 |
| | | Develop and implement a novel program for managing individuals charged with alcohol-related driving offenses, which will provide the judicial system with a cost-effective alternative to jail and reduce rates of recidivism among offenders.  
085144601.3.33  
3.IT-9.1  
Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons |
| | | Work in collaboration with the Guadalupe Regional Medical Center to implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders.  
1268443-05.3.3  
3.IT-3.1  
All cause 30 day readmission rate – NQF 1789 |
| | | Implement a transitional housing facility that is provided consistent with SAMHSA recognized recovery principles.  
1268443-05.3.4  
3.IT-3.8  
Behavioral health/substance abuse 30 day readmission rate |
<table>
<thead>
<tr>
<th>TPI: 137251808</th>
<th>Implement a therapeutic justice model for persons who have been detained and/or incarcerated by Bexar County law enforcement and/or adjudicated by the court for outpatient commitment.</th>
<th>$15,152,433</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>137251808.2.1</strong> – PASS 1</td>
<td>Implement a therapeutic justice model for persons who have been detained and/or incarcerated by Bexar County law enforcement and/or adjudicated by the court for outpatient commitment.</td>
<td><strong>137251808.3.6</strong></td>
</tr>
<tr>
<td><strong>137251808.2.2</strong> – PASS 1</td>
<td>Establish a comprehensive, integrated care management center offering primary and behavioral health care at Prospects Courtyard (PCY) within the Haven for Hope campus.</td>
<td><strong>137251808.3.7</strong></td>
</tr>
<tr>
<td><strong>137251808.2.3</strong> – PASS 1</td>
<td>Embed and integrate primary care services at the Restoration Center, a comprehensive substance abuse treatment facility.</td>
<td><strong>137251808.3.8</strong></td>
</tr>
</tbody>
</table>

**Center for Health Care Services**

**TPI: 137251808**
<table>
<thead>
<tr>
<th>Project Code</th>
<th>Funding Location</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>137251808.2.4</td>
<td>PASS 2</td>
<td>2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Coordinated Community Integrated Care Response for Super-Utilizing Consumers-Expand and Enhance Pilot Project</td>
<td>Expand a current CHCS pilot that is developing a community collaborative response to identifying and providing effective interventions to high utilizers.</td>
</tr>
<tr>
<td>137251808.2.5</td>
<td>PASS 2</td>
<td>2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services: In House Women's Wellness Program (IHWWP)/Day Treatment</td>
<td>Establish a 24-bed comprehensive, safe, structured dormitory for females at the Haven for Hope campus.</td>
</tr>
<tr>
<td>133340307.2.1</td>
<td>PASS 1</td>
<td>2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mobile Crisis Outreach Teams</td>
<td>Implement two Mobile Crisis Outreach Teams. Mobile Crisis Outreach Team (MCOT) activities include Crisis Assessment, Treatment Placement, and Preventive Crisis Support Services.</td>
</tr>
<tr>
<td>TPI: 133340307.2.2 – PASS 1</td>
<td>133340307.3.2</td>
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</tr>
<tr>
<td><strong>2.16.1</strong> Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hill Country Virtual Psychiatric and Clinical Guidance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TPI: 13340307</td>
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<tr>
<td>Provide PCPs and hospitals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions through Psychiatric Consultation.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other USPSTF endorsed screening (PHQ-A and BDI-PC)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>$5,228,544</td>
<td></td>
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<table>
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<tr>
<th>TPI: 133340307.2.3 – PASS 1</th>
<th>133340307.3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.13.1</strong> Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder</td>
<td></td>
</tr>
<tr>
<td>TPI: 13340307</td>
<td></td>
</tr>
<tr>
<td>Add Co-occurring Psychiatric and Substance Use Disorder services throughout the eleven county area served by Hill Country in RHP6.</td>
<td></td>
</tr>
<tr>
<td>Other USPSTF endorsed screening (PHQ-9)</td>
<td></td>
</tr>
<tr>
<td>$3,921,410</td>
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</table>

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<tr>
<th>TPI: 133340307.2.4 – PASS 1</th>
<th>133340307.3.4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.13.1</strong> Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care</td>
<td></td>
</tr>
<tr>
<td>TPI: 13340307</td>
<td></td>
</tr>
<tr>
<td>Establish Trauma Informed Care throughout the eleven counties served by Hill Country in RHP6. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.</td>
<td></td>
</tr>
<tr>
<td>Other USPSTF endorsed screening (CAGE and AUDIT)</td>
<td></td>
</tr>
<tr>
<td>$4,182,825</td>
<td></td>
</tr>
<tr>
<td>Project ID</td>
<td>Description</td>
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<td>------------</td>
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</tr>
<tr>
<td>133340307.2.5</td>
<td>Design, implement, and evaluate whole health peer support for individuals with mental health and/or substance use disorders: Whole Health Peer Support</td>
</tr>
<tr>
<td>TPI: 133340307</td>
<td>Utilize consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide behavioral health services.</td>
</tr>
<tr>
<td>133340307.3.7</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>$1,230,189</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>133340307.2.6</td>
<td>Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Veteran Mental Health Services</td>
</tr>
<tr>
<td>TPI: 133340307</td>
<td>Acquire additional Veteran Peer Coordinators who can actively work to recruit and train veteran peer support providers in a concentrated This project will also include provision of clinical behavioral health services from clinicians who have been trained in cultural competency for the military environment.</td>
</tr>
<tr>
<td>133340307.3.8</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>$1,852,389</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>133340307.2.7</td>
<td>Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Mental Health Courts</td>
</tr>
<tr>
<td>TPI: 13340307</td>
<td>Establish Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services.</td>
</tr>
<tr>
<td>133340307.3.9</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>$1,175,626</td>
<td></td>
</tr>
<tr>
<td>Project ID</td>
<td>Description</td>
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<tr>
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<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>091308902.2.1</td>
<td>2.6.4 Implement other evidence-based health promotion programs in an innovative manner: Comprehensive Teen Pregnancy Prevention</td>
</tr>
<tr>
<td></td>
<td>San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td></td>
<td>TPI: 082426001</td>
</tr>
<tr>
<td>091308902.2.2</td>
<td>2.6.4 “Other” project option: implement other evidence-based health promotion programs in an innovative manner: Neighborhood Based Physical Activity and Health Promotion Project</td>
</tr>
<tr>
<td></td>
<td>San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td></td>
<td>TPI: 082426001</td>
</tr>
<tr>
<td>Proposal ID</td>
<td>PASS 1</td>
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<tr>
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</tr>
<tr>
<td><strong>091308902.2.3</strong></td>
<td>2.6.2 Establish self-management programs and wellness using evidence-based designs: Community Diabetes Project</td>
</tr>
<tr>
<td></td>
<td>San Antonio Metropolitan Health District</td>
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<tr>
<td></td>
<td>TPI: 082426001</td>
</tr>
<tr>
<td><strong>Expand Stanford chronic disease self-management classes in community settings and establish a sub-contract with the YMCA of Greater San Antonio to implement the YMCA Diabetes Prevention Program (YDPP).</strong></td>
<td><strong>Reduce the burden of sexually transmitted diseases and HIV and improve the health status of adolescents and adults in San Antonio, Texas by enhancing disease prevention and control strategies.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>091308902.3.9</strong></td>
</tr>
<tr>
<td></td>
<td>3.IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td></td>
<td><strong>091308902.3.10</strong></td>
</tr>
<tr>
<td></td>
<td>3.IT-9.2 ED appropriate utilization</td>
</tr>
<tr>
<td></td>
<td><strong>091308902.3.11</strong></td>
</tr>
<tr>
<td></td>
<td>3.IT-10.7 Quality of life: other outcome improvement target</td>
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</tr>
<tr>
<td>2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents – Breastfeeding Promotion for Childhood Obesity Prevention</td>
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<tr>
<td>San Antonio Metropolitan Health District</td>
<td></td>
</tr>
<tr>
<td>TPI: 082426001</td>
<td></td>
</tr>
<tr>
<td>Establish a “Baby Café” breastfeeding drop-in center to expand services and attract mothers of all ages and from all sectors of the community. This will be done by providing breastfeeding help and support, from both skilled health professionals, para-professionals, and other mothers, in a friendly, non-clinical, café style environment.</td>
<td></td>
</tr>
<tr>
<td>091308902.2.5 – PASS 2</td>
<td></td>
</tr>
<tr>
<td>091308902.3.15 3.IT-8.9 Other outcome improvement target</td>
<td></td>
</tr>
<tr>
<td>091308902.3.16 3.IT-8.9 Other outcome improvement target</td>
<td></td>
</tr>
<tr>
<td>091308902.3.17 3.IT-8.9 Other outcome improvement target</td>
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<tr>
<td>$4,730,909</td>
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</tbody>
</table>
Section III. Community Needs Assessment

Regional Healthcare Partnership (RHP) 6 comprises approximately 9% of Texas’ population and geography. Like much of Texas, RHP 6 has a high uninsured rate and reported health outcomes are often poor. Key health challenges include limited access to primary and specialty care, unmet mental and behavioral needs, chronic disease, and poor maternal and child outcomes. The need for improved health care infrastructure will continue to increase as the population is expected to grow and more Texans gain health care coverage under the federal Affordable Care Act.

Demographics

Population

The 20 counties in RHP 6 cover 24,734 square miles or approximately 9.5% of the total land area of Texas. In 2010, there were 2.3 million people living in this region, accounting for 9% of the state’s population. Seventy-three percent (73%) of the RHP population resides in Bexar County. The majority of RHP 6 residents are either Hispanic (54%) or Anglo (37%). This differs from the state as whole, which is 46% Anglo and 38% Hispanic.

Forty-three percent of the Bexar County population speaks a language other than English (primarily Spanish) in the home, compared to 34% across the state. The range varies dramatically within the region. For example, 12% of Bandera County residents and 72% of Zavala County residents speak languages other than English outside the home.

In terms of age, 26% of the RHP 6 population includes children under the age of 18 years, while 12% of residents are age 65 years or older. While 73% of the total population resides in Bexar County, only

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66% of the region’s seniors reside there. The counties with disproportionately higher senior populations include Comal, Kerr, Gillespie, and Kendall.4

**Education**

The educational attainment of residents within RHP 6 is consistent with the rest of the state. Nearly 20% of residents ages 25 years and older did not finish high school or obtain a GED. The percent of residents finishing high school varies among counties by a range of 58% (Zavala) to 91% (Kendall).5

**Economics**

In 2010, the per capita income in RHP 6 was $35,989, compared to $38,609 statewide. Individual counties vary widely as evidenced by Zavala County’s per capita income of $17,892 and Gillespie County’s of $44,723.6

In 2010, the unemployment rate for RHP 6 was 7.4%, better than the state’s rate of 8.2%. As expected, the unemployment rate is correlated with education and per capita income and again, varies widely by county. Zavala County had an unemployment rate of 15.6%, while Gillespie County had the lowest rate at 4.8%.7

In 2009, some 380,000 residents, approximately 16% of the population, lived below the poverty line in RHP 6. Forty percent of those living below poverty were children under the age of 18 years. Poverty rates varied significantly by county with Kendall County at 8.6% and Zavala County at 35.6%.8

RHP 6 is home to many companies and organizations that employ a significant number of residents from each of the 20 counties. Some of the major employers are listed in Table 1.

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Table 1. Largest Employers In RHP 6 By County

<table>
<thead>
<tr>
<th>County</th>
<th>Largest Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bandera</td>
<td>Bandera Electric Coop, Bandera ISD, Bandera Rehabilitation Center, Bandera County, Flach Masonry, Flying L Guest Ranch, Mayan Dude Ranch, Medina Children’s Home, Medina ISD</td>
</tr>
<tr>
<td>Bexar</td>
<td>USAA, Valero, University Health System, City of San Antonio, City Public Service, Department of Defense, San Antonio ISD, Methodist Healthcare System, Baptist Health System, University of Texas at San Antonio, University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Comal</td>
<td>Checks In the Mail, Comal ISD, Eden Home, Gristmill Restaurant, HEB Grocery, Lightning Metal Specialties, McKenna Health Management, Mission Valley Fabrics, New Braunfels ISD, New Braunfels Smoker</td>
</tr>
<tr>
<td>Dimmit</td>
<td>Carrizo Springs ISD, Community Services Health Start, Dimmit Memorial Hospital, Middle Rio Grande Workforce, US Border Patrol, Wal-Mart</td>
</tr>
<tr>
<td>Edwards</td>
<td>Champion Laboratories, Kasha Industries, Pallet Solution, Wabash Valley Service Co</td>
</tr>
<tr>
<td>Frio</td>
<td>Pearsall ISD, Frio County, Dilly ISD, City of Pearsall, Chesapeake Energy</td>
</tr>
<tr>
<td>Gillespie</td>
<td>Hill Country Memorial Hospital, Fredericksburg ISD, Knopp Nursing/Retirement Home, HEB, Wal-Mart</td>
</tr>
<tr>
<td>Guadalupe</td>
<td>Texas Power Systems, Seguin Independent School System, Continental, CMC, Tyson</td>
</tr>
<tr>
<td>Kendall</td>
<td>Boerne ISD, Wal-Mart, Mission Pharmacal, HEB, Kendall County</td>
</tr>
<tr>
<td>Kerr</td>
<td>Peterson Regional Medical Center, Kerrville ISD, Kerrville State Hospital, Veterans Administration, Wal-Mart, HEB, Ingram ISD</td>
</tr>
<tr>
<td>Kinney</td>
<td>Rio Grande Electric Cooperative, Brackett ISD</td>
</tr>
<tr>
<td>La Salle</td>
<td>Texas Department of Criminal Justice, Cotulla ISD, City of Cotulla, LaSalle County</td>
</tr>
<tr>
<td>Medina</td>
<td>Medina Valley ISD, Hondo ISD, Devine ISD, Medina Regional Hospital, Medina County</td>
</tr>
<tr>
<td>McMullen</td>
<td>McMullen County ISD, Sam’s Club, Chesapeake Energy, Petrohawk, Swift Energy</td>
</tr>
<tr>
<td>Real</td>
<td>Big Springs Charter School, Leakey ISD</td>
</tr>
<tr>
<td>Uvalde</td>
<td>Southwest Texas Junior College, Uvalde Consolidated ISD, AgriLink Foods, Williamson-Dickie Manufacturing, HEB</td>
</tr>
<tr>
<td>Val Verde</td>
<td>Laughlin Air Force Base, Law enforcement agencies, Val Verde School District, Val Verde Regional Medical Center, City of Del Rio</td>
</tr>
<tr>
<td>Wilson</td>
<td>La Vernia ISD, Floresville ISD, Connally Memorial Medical Center, Wal-Mart, L E Feeds</td>
</tr>
<tr>
<td>Zavala</td>
<td>Crystal City School District, Lopez Health Systems, Inc., Del Monte, Inc., Chesapeake Energy, CML Exploration, Petrohawk</td>
</tr>
</tbody>
</table>

Insurance Coverage

In 2009, some 471,000 residents (24%) of RHP 6 lacked health insurance coverage. A major reason for the lack of coverage was the large number of residents, particularly in rural areas, that work for small businesses or who are self-employed. In Texas, only 31% of firms with fewer than 50 employees offer health insurance. Of those with coverage, 317,000 residents were enrolled in Medicare and more than

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355,000 residents were enrolled in Medicaid. Seventy percent of Medicaid enrollees were children. Of the adults enrolled in Medicaid, 54% were blind and/or disabled.\textsuperscript{12}

**Current Health Care Infrastructure**

In 2009, there were 33 acute care hospitals in RHP 6, including nine public and three private/nonprofit hospitals. In addition, there were four psychiatric hospitals. RHP 6 had a total of 7,430 licensed acute care beds, 77% of which were staffed. Sixty-five percent of the 746 licensed psychiatric beds were staffed.\textsuperscript{13}

In 2010, acute care gross patient revenue in the region totaled $13.7 billion. Net patient revenue totaled $4.7 billion and hospitals provided $1.7 billion in uncompensated care.\textsuperscript{14}

Table 2 shows the number of health care providers in RHP 6 in 2009. As stated previously, the population of RHP 6 represents about 9% of the state’s population, and the percent of providers in RHP 6 is consistent with population distribution. Health professionals within the region tend to be primarily located in Bexar County.\textsuperscript{15}

<table>
<thead>
<tr>
<th>Table 2. Health Care Providers in RHP 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Care Physicians</strong></td>
</tr>
<tr>
<td><strong>Primary Care Physicians</strong></td>
</tr>
<tr>
<td><strong>Physician Assistants</strong></td>
</tr>
<tr>
<td><strong>Registered Nurses</strong></td>
</tr>
<tr>
<td><strong>Licensed Vocational Nurses</strong></td>
</tr>
<tr>
<td><strong>Nurse Practitioners</strong></td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
</tr>
<tr>
<td><strong>EMS Personnel</strong></td>
</tr>
</tbody>
</table>


\textsuperscript{13} Texas Department of State Health Services. Health Currents System. \url{http://www.dshs.state.tx.us/hcquery/}, accessed July 25, 2012.


Nearly every county in RHP 6 is designated as a Health Provider Shortage Area (HPSA) for primary care and/or mental health as shown in the maps below. A HPSA is a geographic area, population group, or health care facility that has been designated by the federal government as having a shortage of health professionals. Sixteen of 20 counties are designated as a HPSA for dental services. HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care.¹⁶

Current Delivery System Initiatives

RHP 6 Performing Providers are currently participating in the following initiatives, some of which are funded by the United States Department of Health and Human Services:

- Partnership for Patients
- EHR Incentive payments
- TORCH grants
- Ryan White funding
- Breast and Cervical Cancer Screening program
- DHHS Health Care Professions grant
- DHHS Male Health Program provides
- Women, Infants and Children (WIC)
- Women’s Health Program
- Family Planning (formerly Title X and XX)
- Acute Care Episode (ACE) Demonstration Program
- Oral Health Workforce grant
- Head Start
- CDC emergency preparedness and response funding
- STD Staff Support Program
- CDC Immunizations Program: Vaccines for Children and 317
- San Antonio Lead Monitor
- Healthy Start Initiative
- Inner City Immunizations
- Strengthening Public Health Infrastructure
- Healthy Homes
- Hepatitis B Vaccine Pilot Program
- Communities Putting Prevention to Work
- HRSA School Based Health grant
- HRSA Residency Training in Primary Care Program
- Texas Nurse Family Partnership
- CPRIT-funded health promotion programs
- Healthcare Access San Antonio (HASA)
- Refugee Resettlement program
Projected Major Changes

Demographics

The total population in RHP 6 is expected to grow 6% between 2010 and 2015. The population change projections for 2015 vary widely by individual counties within RHP 6. The Hispanic population will experience the largest net growth of 106,000 residents. The Anglo population is expected to decrease by 2%.\(^\text{17}\)

According to the Center on Budget and Policy Priorities, there are four contributing factors to Texas’ projected population growth, which also apply to most of the counties in RHP 6. These include:\(^\text{18}\)

1. **“Natural growth”** (i.e. births minus deaths). Texas has the nation’s second highest birth rate which has been attributed to a variety of demographic, socio-economic, and cultural factors. Natural growth accounted for 55% of Texas’ population increase between 2010 and 2011.

2. **Continued international migration** given Texas’ proximity to Mexico. International migration accounted for 18% of Texas’ population growth between 2010 and 2011.

3. **Low cost of living** due to supply of land and low housing prices.

4. **Oil and gas industry.** The recently developed Eagle Ford Shale significantly impacts RHP 6 “producing counties” including Atascosa, Dimmit, Frio, La Salle, McMullen, Wilson, and Zavala, as well as two “peripheral counties” (Bexar, and Uvalde) involved in non-production activity. The shale activity is projected to create nearly 117,000 full-time jobs by 2021.\(^\text{19}\)

Insurance Coverage

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, collectively known as the Affordable Care Act (ACA), were signed into law in March 2010, and, for the most part, upheld by the United States Supreme Court in June 2012. One intent of this law is to increase the accessibility and affordability of health coverage for currently uninsured individuals. This coverage will be available through subsidized insurance exchanges and, if Texas elects, the expansion of Medicaid up to 133% of the Federal Poverty Level. Texas’ current uninsured rate of 24% is projected to decrease to 15% in 2014 even if Texas chooses not to expand Medicaid coverage. If Texas expands


\(^{19}\) University of Texas at San Antonio. Economic Impact of the Eagle Ford Shale, May 2012. [http://utsa.edu/today/2012/05/shalestudy.html](http://utsa.edu/today/2012/05/shalestudy.html), accessed July 25, 2012.

52 ★ RHP 6 Plan ★ March 8, 2013
Medicaid, the uninsured rate is projected to be 12%. Those remaining without coverage would include individuals eligible but electing not to enroll in Medicaid or subsidized programs, individuals not eligible for subsidized coverage, and undocumented residents. RHP 6 expects this legislation to affect its uninsured population in a manner consistent with that of the entire state.

Health Care Infrastructure and Environment

With the rise of insured individuals, the demand on health care infrastructure will also increase. One of the key aims of Texas’ 1115 waiver is to “improve and prepare the health care infrastructure to serve a newly insured population.” This will require improved access to primary and mental health care, effective management of chronic disease, enhanced technology, and innovative payment mechanisms to promote high quality care and reduce the costs associated with that care.

Key Health Challenges

Health Care Quality

According to the Agency for Healthcare Research and Quality’s 2011 report, Texas ranks last in the nation on health care quality. The report is based on 155 quality measures which include disease prevention efforts, deaths from various conditions, cancer treatment, and how well health care providers manage chronic conditions such as diabetes. Under the category of “Types of Care,” Texas scored “weak” on preventive measures, acute care measures, and chronic care measures. Under the category of “Care by Clinical Area,” Texas scored “weak” on diabetes, heart disease, and respiratory measures, and “average” on cancer measures.

The University of Wisconsin Population Health Institute, funded by the Robert Woods Johnson Foundation, publishes an annual County Health Rankings Report. The health outcomes rankings are based on equal weighting of mortality and morbidity measures. The health factors rankings shown in Table 3 are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. Highest rankings (lowest numbers) indicate better performance. Of the 221 Texas counties reviewed, Kendall, Comal, and Gillespie performed well, however Atascosa, Dimmit, Edwards, Frio, Kerr, LaSalle, Real, Uvalde, Val Verde, and Zavala ranked in the lower half of all Texas counties. Kinney and McMullen counties were not ranked in the report.

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21 Texas Healthcare Transformation and Quality Improvement Program.


The Texas Health and Human Services Commission (HHSC) has published various reports related to potentially preventable hospitalizations and readmissions. Between 2005 and 2010, HHSC found that RHP 6 had 125,090 potentially preventable hospitalizations, about 8.5% of the entire state. The conditions studied include bacterial pneumonia, dehydration, urinary tract infection, angina, congestive heart failure, hypertension, asthma, chronic obstructive pulmonary disease, and diabetes. The hospitalizations are considered “potentially preventable” because “if the individual had access to and cooperated with appropriate outpatient health care, the hospitalization would likely not have occurred.” These hospitalizations amounted to $2.9 billion in hospital charges, roughly $1,700 per adult living in the region’s 20 counties.24

A January 2012 Medicaid report found that, excluding newborns, the potentially preventable readmissions rate in the Medicaid population was 3.7% overall, 0.8% for obstetrics, 4% for non-obstetric pediatrics and 8.4% for non-obstetric adult stays.25

### Health Care Provider Shortage and Access to Care

Given the high number of counties in RHP 6 designated as HPSAs, this region, like the rest of the state, is in need of additional providers. Recent reports show Texas ranking 45th in the nation in the number of physicians per capita. The state’s growing population, increased longevity of its residents, vast expanses of rural and border areas, growing prevalence of chronic diseases, greater availability of specialty services, and breakthroughs in medical science are all contributing to an accelerating demand for physicians.26

The shortage of providers is one reason many hospitals report high emergency room utilization. Not only is this an expensive way to deliver health care, but it also means that the individuals accessing this care tend to receive less preventive care, less comprehensive care, and they often delay seeking treatment until the illness is advanced. Greater access to high quality care has been shown to result in improved health outcomes.

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**Mental and Behavioral Health**

In Texas, community mental health centers (CMHC) provide services to a specific geographic area of the state, called the local service area. Four community centers serve RHP 6 as shown in Table 4.

**Table 4. RHP 6 Community Mental Health Centers**

<table>
<thead>
<tr>
<th>Community Center</th>
<th>Counties Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluebonnet Trails Community Services</td>
<td>Guadalupe</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>Atascosa, Dimmit, Frio, LaSalle, McMullen, Wilson, Zavala</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>Bexar</td>
</tr>
<tr>
<td>Hill Country Mental Health and Developmental Disabilities Centers</td>
<td>Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde, Val Verde</td>
</tr>
</tbody>
</table>

In addition to providing services, CMHCs have specific responsibilities. The Texas Department of State Health Services requires each authority to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area.27

A March 2011 report published by the Hogg Foundation for Mental Health and Methodist Healthcare Ministries warns the most severe health profession shortages are in mental health services, with Texas ranking far below the national average in number of mental health professionals per 100,000 residents. Less than 33% of the state’s 48,700 practicing doctors accept Medicaid patients.

Nearly every county in RHP 6 is designated as a HPSA for mental health. Inadequate mental health services results in avoidable costs to hospital and criminal and juvenile justice systems.28 Strategic planning sessions sponsored by the Bexar County Commissioners Court and Methodist Healthcare Ministries identified the following issues:

- Inadequate and fragmented continuum of care for children with behavioral health diagnoses
- Need for integrated behavioral health and primary care services
- Inadequate access to care management and resource navigation
- Inadequate services for individuals who have been arrested or incarcerated either as a result or precipitated by unmet behavioral health needs
- Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders
- Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments

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The FY 2010 Texas Medicaid Managed Care STAR Program Quality of Care Report found that among Medicaid members hospitalized for mental illness, only 45% had a follow-up visit within 7 days of discharge from the hospital, and 72% had a follow-up visit within 30 days of discharge from the hospital. The STAR Program rate for mental health readmission within 30 days was 11%.  

### Chronic Disease
Cardiovascular disease, cancer, unintentional injuries, and diabetes top the list of causes of death in RHP 6. Of the 16,000 deaths in 2008, 60% were due to these potentially preventable causes. Disease management and wellness programs are critical to reducing morbidity and mortality of these diseases.

### Maternal and Child Health
Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester. Six percent of births occurred to girls under 18 years of age and 44% of births were to unmarried mothers. Bexar County, which has the highest number of births in RHP 6, reports an adolescent (ages 13-17 years) pregnancy rate of 30.6 per 1,000 women, compared to 26.1 for the state. This rate is even higher in nine other RHP 6 counties. Nine percent of babies were born with low birth weight. Prematurity and low birth weight can contribute to long term health and economic costs to the family and society.

For children, access to primary and preventive care is especially important. The FY 2010 Texas Medicaid Managed Care STAR Program Quality of Care Report provides the following statistics on utilization of preventive care services for the Bexar Service Area:

- Sixty-five percent of STAR members who turned 15 months old during the measurement year had six or more well-child visits with a physician provider during their first 15 months of life
- Less than 80% of children in their 3rd, 4th, or 5th year of life had at least one well-child visit
- Less than 62% of adolescents had at least one well-care visit.

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2012 Bexar County Community Health Improvement Plan

San Antonio Metropolitan Health District and the Bexar County Community Health Collaborative presented a Community Health Improvement Plan for Bexar County in May 2012. This plan, shown in Table 5, was compiled with input from multiple stakeholders and based on the 2010 Bexar County Community Health Assessment. It sets priorities for health improvement and engages partners and organizations to develop, support, and implement the plan.32

Table 5. Community Health Improvement Plan for Bexar County

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Health Issues33</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating and Active Living</td>
<td>68% of the Bexar County population is overweight</td>
<td>Foster social change and strengthen positive behaviors around healthy eating and active living to ensure access to nutritious foods and build environments that enable all residents to make healthy choices and lead healthy lives.</td>
</tr>
<tr>
<td></td>
<td>77% of respondents reported engaging in some type of activity for exercise.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The diabetes rate in Bexar County is 10% and more than double among African Americans (14%) and Hispanics (13%), compared to Whites (6%).</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>The diabetes rate in Bexar County is 10% and more than double among African Americans (14%) and Hispanics (13%), compared to Whites (6%).</td>
<td></td>
</tr>
<tr>
<td>Healthy Child and Family Development</td>
<td>More than 25% of pregnant women in Bexar County received late or no prenatal care. 9.4% of Bexar County babies are born with low birth weight. 57% of Bexar County Head Start participants reported to have dental caries</td>
<td>Make pregnancy and early childhood the focus of system level changes that support healthy child and family development.</td>
</tr>
<tr>
<td>Safe Communities</td>
<td>Unintentional injuries were responsible for 74 hospitalizations per 10,000 people in 2008, in Bexar County Unintentional injuries were responsible for almost 478 years of potential life lost from age 65 in Bexar County in 2008. Motor vehicle accidents were one of the leading causes of death in Bexar County in 2008 for adults and children.</td>
<td>Develop safe neighborhoods by identifying what works locally, planning how to replicate successes in our neighborhoods, and enhancing systems that respond effectively to community-identified safety needs.</td>
</tr>
<tr>
<td>Behavioral Health and Mental Well-Being</td>
<td>About 6 people per 1,000 are hospitalized for mental disorders every year in Bexar County About 1 person in 10,000 dies every year in Bexar County due to suicide, adjusted for age. In 2008, this rate added up to 245 years of potential life lost per 100,000 under age 65 due to suicide for the residents of Bexar County 28% of youth in Texas reported feeling sad or hopeless every day for two weeks Nearly 10 times as many Hispanic youth utilized state mental health services compared to the number of White and African American youth who utilized the same services.</td>
<td>Improve comprehensive behavioral health services and access for all.</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>14% of Bexar County births in 2008 were to mothers under the age of 20. 46% of births in Bexar County in 2008 were to</td>
<td>Ensure that males and females have access to education and resources to promote sexual</td>
</tr>
</tbody>
</table>

32 2012 Bexar County Community Health Improvement Plan.
33 2010 Bexar County Community Health Assessment.
single mothers. For chlamydia, gonorrhea, syphilis, and HIV, the number of cases increased between 2003 and 2008. This increase was most pronounced for Chlamydia where the number of cases increased from 6,742 in 2003 to 8,849 in 2008.

Rural Health Care

More than half of the counties in RHP 6 (Dimmit, Edwards, Frio, Gillespie, Kerr, Kinney, LaSalle, McMullen, Real, Uvalde, Val Verde, and Zavala) are designated by the Health Resources and Services Administration’s Office of Rural Health Policy as rural counties. According to a Kronkosky Charitable Foundation Research Brief on Rural Healthcare, rural populations face a variety of economic, cultural, social, educational, and political disparities, which reduce the ability to live a healthy life, and the need for all types of health care services continues to grow. Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals are government-supported facilities that serve as safety net health care providers for rural populations. Table 6 lists the Federally Qualified Health Centers serving RHP 6.

Table 6. Federally Qualified Health Centers in RHP 6

<table>
<thead>
<tr>
<th>Health Care Facility</th>
<th>Counties Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atascosa Health Center, Inc.</td>
<td>Atascosa, Wilson</td>
</tr>
<tr>
<td>CommuniCare Health Center</td>
<td>Bexar</td>
</tr>
<tr>
<td>Community Health Centers of South Texas</td>
<td>Guadalupe</td>
</tr>
<tr>
<td>Community Health Development, Inc.</td>
<td>Real, Uvalde</td>
</tr>
<tr>
<td>CentroMed</td>
<td>Bexar, Comal</td>
</tr>
<tr>
<td>South Texas Rural Health Services</td>
<td>Dimmit, LaSalle, Medina, Frio, Uvalde</td>
</tr>
<tr>
<td>United Medical Centers</td>
<td>Kinney, Val Verde</td>
</tr>
<tr>
<td>Vida Y Salud Health Systems, Inc.</td>
<td>Zavala</td>
</tr>
</tbody>
</table>

An additional 33 providers are designated as Rural Health Clinics by the Centers for Medicare and Medicaid. One hospital, Medina Community Hospital, is designated as a Critical Access Hospital. Eight counties in RHP 6 do not even have hospitals: Bandera, Edwards, Kendall, Kinney, LaSalle, McMullen, Real, and Zavala.

The National Rural Health Association (NRHA) has identified the following issues of particular interest to rural communities:38

- Access to health care services, particularly health disparities and physician shortages
- Health information technology to improve communication and health care quality
- Mental health services, particularly relating to provider shortages and lack of insurance coverage
- Substance abuse
- Oral health

While 24% of the entire region is uninsured, the uninsured rate for the designated rural counties of RHP 6 is 31%, and the ten rural counties make up 61% of the region’s geographic area. This underscores the importance of safety net providers and helps explain why the issues described above of are particular relevance to RHP 6. The residents of these counties tend to be older and less educated, experience lower per capita income and more poverty than the region as a whole, further compounding the challenges faced here.

**Conclusion**

RHP 6 represents a vast geographic area of both rural and urban communities where rates of insurance coverage are low and poor health outcomes are common. Continued population growth is expected to exacerbate current health challenges, including limited access to primary and specialty care, unmet mental and behavioral health needs, prevalence of chronic disease, and poor maternal and child outcomes. Near-term decisions, including potential Medicaid expansion and the prevalence of the use of health insurance exchanges, could have significant impact on the health status of residents and outcomes of RHP 6 initiatives. The opportunity to implement transformative projects through the 1115 waiver funding will help RHP 6 address the needs of this community.

**Summary of Community Needs**

University Health System, the RHP 6 Anchor, conducted the community needs assessment with input from the Performing Providers and other stakeholders. Demographic, insurance, and health care infrastructure data were collected from HHSC and United States Census resources and compiled for each county in the region. Hospital, university, health department, and community mental health center leaders reviewed and validated these data and provided comment on anticipated changes to these measures throughout the waiver period. These leaders and other stakeholders also provided specific information on initiatives funded by the U.S. Department of Health and Human Services, and health care needs specific to their local communities. The draft community needs assessment was posted to our dedicated RHP 6 Web site (www.TexasRHP6.com) to allow public review and comment. These contributions from the public and our partners, in conjunction with a variety of data sources available via the internet, provided the content for this needs assessment.

The following table summarizes the needs that exist throughout the region. RHP 6 plans to address these needs through the selected DSRIP projects.

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### Table 7. Summary of RHP 6 Needs

<table>
<thead>
<tr>
<th>Identification Number</th>
<th>Brief Description of Community Needs Addressed through the RHP Plan</th>
<th>Data Source for Identified Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>CN.1</td>
<td>Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.</td>
<td>Agency for Health care Research and Quality - 2011 State Snapshots</td>
</tr>
<tr>
<td>CN.2</td>
<td>A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.</td>
<td>Texas Department of State Health Services - Health Currents System</td>
</tr>
<tr>
<td>CN.3</td>
<td>Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.</td>
<td>United States Census Bureau. 2009 Small Area Health Insurance Estimates United States Department of Health and Human Services. Health Resources and Services Administration</td>
</tr>
<tr>
<td>CN.4</td>
<td>There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.</td>
<td>United States Department of Health and Human Services. Health Resources and Services Administration 2010 Bexar County Community Health Assessment</td>
</tr>
<tr>
<td>CN.5</td>
<td>Lack of interconceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.</td>
<td>2010 Bexar County Community Health Assessment FY 2010 Texas Medicaid Managed Care STAR Program Quality of Care Report</td>
</tr>
<tr>
<td>CN.6</td>
<td>High rates of communicable disease and potential for vaccine preventable diseases due to low vaccine coverage levels in the community.</td>
<td>Bexar County Community Health Improvement Plan, the National Immunization Survey, and the Texas 2011 STD Surveillance Report.</td>
</tr>
</tbody>
</table>
Section IV. Stakeholder Engagement

A. RHP Participants Engagement

Providers within RHP 6 have been actively engaged in 1115 waiver activities since before it was approved by the Centers for Medicare and Medicaid Services. University Health System’s President and Chief Executive Officer, George B. Hernandez, participates in HHSC’s Executive Waiver Committee which began in June 2011. Mr. Hernandez continued to be in regular communication with public hospitals around the state and local private hospitals in and around Bexar County. Industry groups such as Teaching Hospitals of Texas (THOT), Texas Organization of Rural and Community Hospitals (TORCH), the Texas Hospital Association (THA), the Texas Medical Association (TMA), and the Texas Council of Community Health Centers, served to educate their members regarding 1115 waiver developments.

In February 2012, HHSC created a Clinical Champion’s Workgroup. Meetings and conference calls were held between February and May 2012. RHP 6 was represented by the following physicians who contributed to the development of the RHP Planning Protocol.

- Dr. Bryan Alsip, Chief Medical Officer, University Health System
- Dr. Barbara Turner, University of Texas Health Science Center at San Antonio
- Dr. John Holcomb, Texas Medical Association
- Dr. Jim Martin, CHRISTUS Santa Rosa Health System
- Dr. Jan Patterson, University of Texas Health Science Center at San Antonio

During the month of February 2012, University Health System contacted hospital CEOs and county judges in the proposed region and adjacent areas to provide education about the 1115 waiver and gauge interest in participating with Bexar County. Based the feedback collected from these conversations, University Health System submitted the preliminary RHP Regions Survey to HHSC on February 24, 2012.

On March 21, University Health System hosted a regional stakeholder meeting with HHSC. University Health System mailed letters to hospital CEOs, county judges, and county commissioners inviting them to attend. During the meeting, Stanley Stewart provided an overview of the waiver. The meeting was attended by 57 individuals.

Following the stakeholder meeting, and as HHSC finalized the geography of Region 6, numerous phone conversations and meetings began taking place. Performing Providers began networking with University Health System and each other, sharing information with their boards and stakeholders, and discussing new opportunities to transform healthcare with entities they might not have worked with previously. A list of these meetings is included in Addendum A.

As the Anchor, University Health System led efforts to inform RHP participants and stakeholders regarding the 1115 Waiver through its dedicated Web site: www.TexasRHP6.com, which was launched
May 1, 2012. This site has served both to educate and inform as well as to receive input into the RHP 6 plan and DSRIP projects. A secure portal within the Web site allows Performing Providers to submit their RHP organization information, contribute to development of the community needs assessment, propose initial plans for DSRIP projects, and provide examples of stakeholder engagement from their communities.

Further, University Health System hosted two meetings with other anchoring entities - El Paso Hospital District and University of Texas Health Science Center at Tyler – to share anchor processes, best practices and lessons learned. University Health System’s CEO gave a waiver presentation to the Ector County Hospital District (Region 14). University Health System also shared its RHP 6’s valuation methodology with Regions 12 and 18.

Given the large number and value of projects proposed for our region, University Health System will promote and facilitate learning collaboratives through the remaining four years of the demonstration program. Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:

- Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaboratives to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.

Additionally, University Health System plans to provide support to RHP 6 participants in meeting semi-annual reporting requirements. University Health System has contracted with Performance Logic, a vendor that hosts a web-based project management tool. Previously implemented by hospitals participating in the California Medicaid waiver, the tool includes a module specially designed to manage the categories, milestones, measures, values, and Intergovernmental transfer (IGT) contributions unique to DSRIP projects.
B. Public Engagement

The dedicated Web site has proven to be a robust tool for communicating with partners and stakeholders in our region. Screen shots of the website are included in Addendum B. As of December 18, 1,653 unique individuals have visited the website, creating a total of 17,912 page views. The average visitor spends nearly five minutes viewing the site. The site includes an overview of the 1115 waiver, news updates, state waiver resources, and provides the opportunity for visitors to submit comments, ask questions, and sign up to receive emails. Over 170 visitors have submitted their email addresses. Using this database, University Health System has emailed numerous updates about how RHP 6 is participating in the 1115 waiver. Examples of these communications are included in Addendum C.

University Health System leaders have met and/or held conference calls with numerous stakeholders and local businesses interested in participating in the waiver. Examples include:

- Federally Qualified Health Centers
- Home health agencies
- Information Technology vendors
- County and city officials
- Indigent care coordinators
- Advocacy groups
- Healthcare Access San Antonio

In addition, University Health System leaders served as invited guest speakers at meetings of the following organizations:

- Teaching Hospitals of Texas (March 30, 2012)
- Bexar County Medical Society (May 23, 2102)
- Alamo Area Council of Governments (June 27, 2012)
- The Health Collaborative Board of Directors (August 2, 2012)
- Methodist Healthcare Ministries (December 3 and December 4, 2012)

All but one Performing Provider eligible for a Pass 1 allocation are participating in the DSRIP incentive program. South Texas Regional Medical Center will participate in the Uncompensated Care Pool only.

On October 25, 2012, University Health System announced its upcoming public meeting scheduled for November 7, 2012. The announcement was emailed to stakeholders, posted on the Web site, and communicated publicly via a press release on November 2, 2012. A draft of the RHP Plan (including Pass 1 projects) was posted to the website on November 6, 2012. Stakeholders were invited to submit comments electronically and/or in person at the public meeting. The public meeting was attended by 55 individuals representing 35 organizations. The official public comment period for Pass 1 of the RHP Plan was November 6 through November 9, 2012.

University Health System hosted a webinar on December 13, 2012, to update stakeholders on the RHP Plan. The meeting was announced November 30, 2012, through email and on the Web site. An updated
draft of the RHP Plan was posted December 11, 2012. The official public comment period for the Final RHP Plan was December 11 through December 14, 2012.

Since its launch, the TexasRHP6.com website has included a “Comments and Feedback” tool which allows all stakeholders to submit questions and feedback to the anchor at any time. University Health System will continue to update and engage stakeholders using the dedicated website and emails targeted to stakeholders who provide email addresses. Additional public meetings will be held as needed.
Section V. DSRIP Projects

A. RHP Plan Development

RHP 6 is assigned to Tier 2 for the 1115 Medicaid Waiver. According to the Program Financing and Mechanics Protocol, Tier 2 regions contain at least 7 percent and less than 15 percent share of the statewide population under 200 percent Federal Poverty Level as defined by the U.S. Census Bureau: 2006-2010 American Community Survey (ACS) for Texas. As a Tier 2 region, RHP 6 must select a minimum of 12 projects from Categories 1 and 2 combined, with at least 6 of the 12 projects selected from Category 2.

RHP 6 has identified 79 projects in Pass 1, 36 projects in Pass 2, and five projects in the Anchor Pass (Pass 3) for a total of 120 projects. Due to the size of our region, RHP 6 implemented Pass 1 and 2 using a decentralized approach. Performing Providers were encouraged to identify projects that were most appropriate for their service areas. In most cases, the services areas included the county where the provider is based. The Community Mental Health Centers (CMHCs) are unique because their service areas span multiple counties, and in some cases, regions. This provided an opportunity for new networking and collaboration to occur that had not existed previously. Many hospital providers collaborated with their county indigent care programs, Federally Qualified Health Centers (FQHCs) and other provider practices and stakeholders in developing projects best suited to meet the needs of their residents. In Bexar County, numerous meetings were held between University Health System, The Center for Health Care Services, private hospital providers, and other stakeholders to discuss potential projects, make selections, and ensure projects were not duplicative.

The process for submitting projects was iterative and began July 9, 2012, when University Health System first requested submission of projects. This occurred early in the development of the RHP Planning Protocol, which was ultimately finalized and approved on October 1, 2012. This early submission, and those that followed, provided opportunities for regional partners to become familiar with the type of projects eligible for incentives and to share ideas with one another. University Health System made a sequence of updates to the project narrative templates as we received new information from HHSC and revisions to the RHP Plan template and protocols. Final Pass 1 narratives and electronic workbooks were due October 26, which provided time for University Health System to conduct an administrative review of proposed projects and provide feedback to performing Providers to ensure the formats and content were in compliance with Waiver protocols.

As Performing Providers submitted their project proposals, University Health System compiled matrices to share project information with regional partners and encouraged them to network with each other as appropriate. University Health System also reviewed the proposed valuations of similar projects across the region and assessed these for consistency. A complete list of projects considered, including those not submitted in the RHP Plan are listed in Addendum D.
University Health System, with input from Performing Providers, compiled the community needs assessment and posted the document on our RHP 6 Website on August 28, 2012. Each county varies in terms of its demographics, socioeconomics, and current health care infrastructure, but nearly every county in RHP 6 is designated as a Health Provider Shortage Area (HPSA) for primary care mental health and/or dental care. As a result, the counties within RHP 6 face similar community needs and health challenges.

- RHP 6 seeks to improve quality and patient satisfaction.
- A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.
- Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.
- There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.
- Lack of interconceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.
- High rates of communicable disease and potential for vaccine preventable diseases due to low vaccine coverage levels in the community.

The 20 counties are committed to working together to make significant progress over the next five years toward addressing our community needs, expanding access to care, and achieving the specific triple aim goals of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways. RHP 6 also strives to leverage local and federal waiver financing to:

- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth
- Improve and prepare the health care infrastructure to serve a newly insured population

On September 6, University Health System proposed a methodology for Performing Providers to use in evaluating, prioritizing, and selecting their projects. Many providers reported that this methodology was helpful, and two other regions (12 and 18) requested permission to use it as well. While RHP 6 did not require Providers to use this methodology, many did submit projects that scored highest on the evaluation criteria.

Each Performing Provider was given a custom template containing their Pass 1 allocation spread across all four categories per the PFM Protocol. University Health System also included a recommended range for the number of Category 1 and/or Category 2 projects anticipated from each Performing Provider.
based on HHSC’s allocation, maximum project value, and provider size. Using the template, Performing Providers were asked to list and briefly describe each proposed project, and then scored the project(s) using the criteria below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
</table>
| Achieves Waiver Goals | Relative to your other proposed projects, to what extent does this project achieve the following waiver goals:  
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways  
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties  
- Further develop and maintain a coordinated care delivery system  
- Improve outcomes while containing cost growth  
Performing Providers may consider the following attributes when scoring projects on this domain:  
- Will the project impact one or more of the goals?  
- Does the project primarily impact Medicaid and/or uninsured residents?  
- How significant is the expected impact? To what extent will it “move the dial”?  
- Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact? |
| Addresses Community Need(s) | Relative to your other proposed projects, to what extent does this project address community needs? Performing Providers are advised to reference the draft RHP Community Needs Assessment, available at [http://www.texasrhp6.com/rhp-plan/](http://www.texasrhp6.com/rhp-plan/).  
Performing Providers may consider the following attributes when scoring projects on this domain:  
- Will the project address one or more community needs?  
- How significant is the expected impact? To what extent will it “move the dial”?  
- Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact? |
| Project Scope | Relative to your other proposed projects, how “big” is this project? Performing Providers should consider targeted improvements/increases in:  
- Outreach to the targeted population  
- Patient visits/encounters  
- Providers recruited/trained  
- Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations |

Addresses Community Need(s)  
Scale:  
1 to 5  
1=Minimal impact on community need(s)  
5=Greatest impact on community need(s)  

Achieves Waiver Goals  
Scale:  
1 to 5  
1=Minimal impact on waiver goals  
5=Greatest impact on all waiver goals  

Project Scope  
Scale:  
1 to 5  
1=Small numbers/percent of population impacted  
5=Large numbers/percent of population impacted
The Delivery System Reform Incentive Program (DSRIP) projects proposed in this plan address the needs of the broader community. Projects span the breadth of opportunities presented in the RHP Planning Protocol. Projects include expanding medical homes and primary care, increasing access to specialists, implementing technology to perform telemedicine and manage patient registries, and numerous other initiatives. The projects differ in size, scope, and targeted population, but each is geared to achieve specific outcome measures and population-focused improvements.

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

As described above, University Health System recommended Performing Providers use four criteria to value DSRIP projects, specifically:

1. To what extent does it achieve waiver goals?
2. To what extent does it address community needs?
3. What is the project scope?
4. What is the project investment?

For each proposed project, the scores across each of the criteria in the proposed methodology were summed to produce a total score, called the Value Weight of Project. Using this assessment, Performing Providers were able to value projects for submission to the RHP Plan. The template calculated initial project values for the selected projects based on the Performing Provider’s allocation of funding and project scores, as shown in the example below:

<table>
<thead>
<tr>
<th>Total DSRIP Potential Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY2</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>$500,000</td>
</tr>
</tbody>
</table>

| Brief Project Description | Value Weight of Project | Value | | | |
|---------------------------|-------------------------|-------| | | |
| | | | | | |
| Open a school-based clinic at Waiver Elementary School | 18 | $255,000 | $480,000 | $675,000 | $1,026,000 | $2,436,000 |
| Implement scheduling model at Waiver Clinic | 12 | $170,000 | $320,000 | $450,000 | $684,000 | $1,624,000 |
| **TOTAL CATEGORY 1 AND 2** | **30** | **$425,000** | **$800,000** | **$1,125,000** | **$1,710,000** | **$4,060,000** |
| | | | | | |
| TOTAL CATEGORY 3 | | | | | $1,365,000 |
| TOTAL CATEGORY 4 | | | | | $575,000 |

Performing Providers were advised that they may need to adjust the number of projects and/or the project values upon consideration of such factors as availability of local matching funds (IGT) and consistency of project valuations across the region. Category 3 measures were often valued using a similar distribution. Many providers also conducted more detailed valuations for their projects by assessing the anticipated investments and community benefit, particularly savings resulting from avoiding unnecessary healthcare costs. The likelihood that a project would reduce morbidity and mortality was also factored into the valuation of many projects. Further, the Community Mental Health Centers worked together with their industry association to engage a health economist in valuing their projects. This was important since many of their projects cross regional boundaries and these organizations placed great emphasis on ensuring consistency throughout the state.
Project valuations do range significantly within our region. This is attributed to the diversity of providers and markets they serve. Given that 75% of the region’s population lives in Bexar County, it was not surprising that the project valuations for Bexar County providers would be valued much higher than similar projects for smaller hospitals in rural counties.

**DSRIP Projects narratives and tables are included on the following pages:**

Category 1: Infrastructure Development ................................................................................................. 71

Infrastructure development projects lay the foundation for delivery system transformation through investments in technology, tools, and human resources. Performing Providers participating in Category 1 projects may include hospitals, community mental health centers (CMHCs), local health departments, physician practices affiliated with academic science health centers, and physician practices not affiliated with academic health science centers, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Category 2: Program Innovation and Redesign ..................................................................................... 615

Program Innovation and Redesign projects emphasize the piloting, testing, and replicating of innovative care models. Performing Providers participating in Category 2 projects may include hospitals, community mental health centers, local health departments, physician practices affiliated with academic science health centers and physician practices not affiliated with academic health science centers, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Category 3: Quality Improvements ...................................................................................................... 1070

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

Category 4: Population-Focused Improvements (Hospitals Only) ...................................................... 1591

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

- Domain 1: Potentially Preventable Admissions
- Domain 2: Potentially Preventable Readmissions – 30 days
- Domain 3: Potentially Preventable Complications
- Domain 4: Patient-Centered Healthcare
- Domain 5: Emergency Department
- **Optional** Domain 6: Children and Adult Core Measures
C. Category 1: Infrastructure Development

Identifying Project and Provider Information:

Title: 1.1.1 Establish more primary care clinics: Expand Primary Care Capacity
Unique RHP ID#: 159156201.1.1 – PASS 1
Performing Provider: VHS San Antonio Partners, LLC d/b/a Baptist Health System
Performing Provider TPI: 159156201

Project Summary:

Provider Description: Baptist Health System includes five acute- (Baptist Medical Center (623 beds), Mission Trail Baptist Hospital (110 beds), North Central Baptist Hospital (280 beds), Northeast Baptist Hospital (379 beds), and St. Luke’s Baptist Hospital (282 beds)) which offer 1,674 licensed beds. In 2011, Baptist Health System was recognized by U.S. News and World Report for earning more, high performing specialty rankings (5) than any other health system in the San Antonio metropolitan area. All five hospitals have earned Accredited Chest Pain Center designation, as well as Primary Stroke Center Certification. Medicare has designated each as Texas’ only Medicare Value Based Care Centers. The system also includes Baptist Regional Children’s Center, Baptist Breast Center, HealthLink wellness and fitness center, Baptist M&S Imaging Centers, community health and wellness programs, ambulatory services, rehabilitation services, air medical transport, School of Health Professions, and other health-related services and affiliations. It is part of the Nashville, Tennessee-based Vanguard Health Systems.

Intervention(s): This project will establish additional primary care locations in Bexar County and add incremental primary care providers thus increasing the number of patients receiving timely primary care services in Bexar County for both acute illness and chronic disease management.

Need for the project: There is a shortage of primary care providers in Baptist Health System’s primary service area. Per the 2011 Carnahan report there was a need for 413 additional Primary care providers in our five sites’ service areas. The prevalence of chronic disease in RHP 6 as demonstrated in the Community Needs Assessment, particularly diabetes and CHF, is further complicated by a shortage of providers, high % of uninsured making Texas last in the nation in health care quality.

Target population: Bexar County residents needing a primary care provider. The shortage of healthcare providers in RHP6 is further complicated by almost half a million uninsured residents (471,000 in 2009). The uninsured and those with Medicaid are the most underserved as many physician practices do not take these patients. All of our primary care sites accept uninsured and Medicaid patients. Our sites cover the northeast, north central, west, downtown and southeast county. We are locating new providers adjacent to new freestanding ED locations (> 20% uninsured) which will provide a draw and referral potential so patients will know where new providers are and days/hours of service. BHS is also targeting a large downtown location and south Bexar County which is the most underserved, highest uninsured or Medicaid related patient population.

Category 1 or 2 expected patient benefits:

Provide incremental primary care visits ranging from a minimum of 5,433 additional visits in DY 2 to a minimum of 16,300 additional visits by DY5. Our clinics and sites all accept Medicaid plans and self pay patients.

Potential indigent population targeted through this expansion is incremental primary care visits approximating:
DY 2 + 851
DY 3 + 6399
DY 4 + 8495
DY 5 + 8753
TOTAL = 24,899  or  53% of incremental visits projected.
Category 3 outcomes:  Diabetes Care: HbA1c poor control (<9%).

<table>
<thead>
<tr>
<th>Project Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist Health System (BHS / Baptist) will <strong>improve primary care access</strong> for our community through Baptist Managed Service Organization (MSO) and supporting our hospitals with recruitment/relocation of providers targeting underserved areas by <strong>establishing more primary care clinics and providers increasing number of primary care visits</strong> year over year.</td>
</tr>
</tbody>
</table>

The **goals of this project** will be to increase access to primary care providers by (1) adding additional primary care offices (2) adding additional physician providers and (3) otherwise increase availability and choice for our community to manage their health in an appropriate setting using a primary care provider.

This project allows San Antonio/RHP6 to develop a more robust primary care delivery platform. By increasing provider availability, those needing primary care can develop medical home relationships and improve preventive and health maintenance care. With expanded access to primary care, patients will have improved disease prevention, improved management of chronic conditions and regular follow up care which can intervene and prevent worsening conditions. This will not only reduce the use of the ER for primary care but will improve population health particularly related to the chronic diseases that are prevalent in RHP6 such as diabetes, cardiovascular disease and cancer.

There are **multiple challenges** to this issue including: identification and engagement of those in need, provide resources for initiatives, identification and incentivization of providers to serve this population, and the members of this population taking ownership for their own health needs. This project will seek to recruit and incentivize primary care physicians and provide automated tools to track, monitor and improve chronic disease management of our MSO patient population—as an example, BHS will also provide our MSO physicians with valuable tools such as Crimson for monitoring and improving our performance in managing the health of our patients.

The **five year expected outcome** is that by increasing primary care sites and providers, Baptist will meet community/population needs of improving access to primary care. Disease prevention will be increased by improved access to care and chronic conditions will be better managed by regular primary care and early interventions. These outcomes will be achieved by accomplishing the project goals noted above.

This **project meets the RHP Regional Goals**:
- **Triple Aim**: assuring patients receive high-quality, patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
• Further develop and maintain a coordinated care delivery system
• Improve outcomes while containing cost growth

This project meets the following RHP identified Community needs:
CN.1 Texas ranks last in the nation on health care quality
CN.2 A higher prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.
CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsured combined with health care provider shortages.

Through BHS Operational Improvement Office, BHS staff will use P-3 Quality Improvement Milestone to further enhance the Process Improvement (PI) impact on improving care, quality and cost for our patients.

Starting Point/Baseline:
BHS MSO had 54,334 patient visits in existing 11 Primary Care Sites for Calendar year ending 12–31-11 which will be the baseline. Adding new locations and/or providers will increase patient access and number of patient visits beginning 1-1-2012.

We will track both the # of new locations opened after 1-1-2012 and the incremental patient visits/encounters performed annually in supported Primary Care locations and will report increased visits > 54,334.

Rationale:
The reason for selecting this project is that currently Baptist hospitals’ service areas have a demonstrated need for Primary Care Providers of BMC = 114, MTB = 136, NEB = 152 and SLB = 11 or a total for the BHS market of 413 Primary Care providers per the 2011 Carnahan Report.
BHS will recruit/employ/relocate Primary Care providers to serve Bexar County needs by expanding primary care physicians in these key geographical areas.

This project is aligned with the Triple AIM Goals:
- Increases access for all patients including Medicaid and uninsured patients
- Increasing access to physicians and specialists improves patient outcomes through chronic disease management and earlier intervention for acute conditions
- Eliminates inappropriate and costly use of Emergency Room visits

This project also aligns with the RHP 6 Community Needs Assessment by improving access, outreach and care for the areas’ underserved and chronically diseased patient population.
- RHP 6 is expected to have 6% population growth with Bexar County up to 15% growth between 2010- 2015; and Texas ranks 45th in the nation in # of physicians per capita.
Increasing access improves disease prevention, patient outcomes through chronic disease management and earlier intervention for acute conditions
- Eliminates inappropriate and costly use of Emergency Room visits

This project certainly is in accord with national initiatives such as Accountable Care organizations. This project meets Community needs CN.1, CN.2, CN.3 as noted in the narrative section above.
**Related Category 3 Outcome Measure(s):**

Texas ranks last in the nation in healthcare quality and weak in quality of diabetes care. The diabetes rate in Bexar County is 10% overall and the rate of diabetes for African Americans and Hispanic is more than double the rate Whites. BHS primary care sites have selected Category 3 Project outcome measure:

| \_IT-1.10 Diabetes Care: HbA1c poor control (> 9%) - NQF 0059 Stand Alone Measure |
| Baptist MSO new location employed primary care practitioners will reduce year over year the % of their patient practice meeting the identified criteria with an HbA1c > 9%.

**Relationship to other Projects:**

This project would have the added advantage of developing/preparing staff for the medical home concept:

| Category 2 : Project Area 2.1 Enhance/Expand Medical Homes |
| Category 2 : Project Area 2.3 Redesign Primary Care |
| Category 2: Project Area 2.11 Conduct Medication Management |

Expanding access to Primary Care practitioners in our underserved areas also supports the patient population focused improvements in Category 4 : Population Focused Measures

| RD-1 Potentially Preventable Admissions |
| 1. Congestive Heart Failure Admission rate |
| 2. Diabetes Admission rate |
| 4. Chronic Obstructive Pulmonary Disease Admission rate |
| 5. Bacterial Pneumonia immunization |

| RD-2 30 day readmissions |
| 1. Congestive Heart Failure Admission rate |
| 2. Diabetes Admission rate |
| 4. Chronic Obstructive Pulmonary Disease Admission rate |
| 5. Stroke |

**Relationship to Other Performing Providers’ Projects in the RHP:**

CHRISTUS facilities, University Health System, and Baptist have all identified the expansion of Primary care as a Category 1 Project and there is demonstrated need for all efforts as evidenced by the need for 413 more primary care providers just in Baptist hospital primary service areas.

**Plan for Learning Collaborative:**

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.
**Project Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, Baptist took into account the extent to which the expansion of primary care would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The expansion of primary care clinics addresses a substantial, community need to increase access to primary care while advancing the Waiver goal of improving outcomes while curbing the risk of healthcare costs. Primary care is one of the most cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th>159156201.1.1</th>
<th>1.1.1</th>
<th>N/A</th>
<th>1.1.1 Establish more primary care clinics: Expand primary care capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
<td>TPI - 159156201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): 159156201.3.1</td>
<td>3.IT-1.10</td>
<td>Diabetes Care: HbA1c poor control (&gt;9.0%)-NQF 0059 Stand Alone Measure</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 6</strong></td>
</tr>
<tr>
<td>[P-1] Establish additional/expand existing/relocate primary care clinics</td>
<td>[P-1] Establish additional/expand existing/relocate primary care clinics</td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td><strong>Metric 1 [P-1.1]: [# of additional clinics or expanded hours or space]</strong></td>
<td><strong>Metric 1 [I-12.1]:</strong></td>
<td><strong>Metric 1 [I-12.1]:</strong></td>
</tr>
<tr>
<td>Baseline/Goal: # Primary Care Clinics 1/1/2012 with Goal of adding a minimum of two new locations by 9/30/2013</td>
<td>[Documentation of increased providers &amp; staff and/or clinic sites] Baseline/Goal: Add minimum of one additional location by 9/30/14</td>
<td>Total # of primary care visits Baseline/Goal: Baseline is 54,334 annual visits and the DY4 goal will be an increase of 25% r +13,584 over Baseline for the year ending 9/30/2015</td>
<td>Total # of primary care visits Baseline/Goal: Baseline is 54,334 annual visits and the DY5 goal will be an increase of 30% or 16,300 over Baseline for the year ending 9/30/2016</td>
</tr>
<tr>
<td>Milestone 1 Estimate Incentive Payment: $1,350,539</td>
<td>Milestone 3 Estimated Incentive Payment: $1,473,366</td>
<td>Milestone 5 Estimated Incentive Payment: $2,955,298</td>
<td>Milestone 6 Estimated Incentive Payment: $2,441,334</td>
</tr>
</tbody>
</table>

**Milestone 4**

[I-12] Increase primary care
[I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1] Total # of primary care visits**

**Baseline/Goal:** Baseline is 54,334 annual visits and the DY2 goal will be an increase of 10% or +5,433 over Baseline for the year ending 9/30/2013.

Data Source: BHS Financial Records

Milestone 2 Estimated Incentive Payment: $1,350,540

**Metric 1 [I-12.1] Total # of primary care visits**

**Baseline/Goal:** Baseline is 54,334 annual visits and the DY3 goal will be an increase of 20% or +10,867 over Baseline for the year ending 9/30/2014.

Data Source: BHS Financial Records

Milestone 4 Estimated Incentive Payment: $1,473,366

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $2,701,079</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,946,732</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,955,298</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,441,334</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $11,044,444</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Identifying Project and Provider Information:**

<table>
<thead>
<tr>
<th>Title:</th>
<th>1.9.2 Improve access to specialty care: Expand Specialty Care Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>159156201.1.2 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>159156201</td>
</tr>
</tbody>
</table>

**Project Summary:**

**Provider Description:** Baptist Health System includes five acute- (Baptist Medical Center (623 beds), Mission Trail Baptist Hospital (110 beds), North Central Baptist Hospital (280 beds), Northeast Baptist Hospital (379 beds), and St. Luke’s Baptist Hospital (282 beds)) which offer 1,674 licensed beds. In 2011, Baptist Health System was recognized by U.S. News and World Report for earning more, high performing specialty rankings (5) than any other health system in the San Antonio metropolitan area. All five hospitals have earned Accredited Chest Pain Center designation, as well as Primary Stroke Center Certification. Medicare has designated each as Texas’ only Medicare Value Based Care Centers. The system also includes Baptist Regional Children’s Center, Baptist Breast Center, HealthLink wellness and fitness center, Baptist M&S Imaging Centers, community health and wellness programs, ambulatory services, rehabilitation services, air medical transport, School of Health Professions, and other health-related services and affiliations. It is part of the Nashville, Tennessee-based Vanguard Health Systems.

**Intervention(s):** This project establishes additional specialty care locations and providers in Bexar County increasing patient access for timely, specialty care services for acute and chronic disease management.

**Need for the project:** There is a shortage of specialty care providers in Baptist Health System’s primary service area. For example, per the 2011 Carnahan report there was a need for +108 new cardiac care providers, +79 psychiatrists, and +301 additional providers for pediatric related specialties.

The prevalence of chronic disease in RHP 6 as demonstrated in the Community Needs Assessment, particularly diabetes and CHF, is further complicated by shortage of providers, high % of uninsured making Texas last in the nation in health care quality. The CNA also identifies a shortage of high quality mental and behavioral health services and a lack of inter-conceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.

**Target population:** Bexar County residents needing improved access to specialty care in cardiac disease, psychiatry, maternal/infant health and other targeted specialties including hospitalists who are trained to manage acute hospital conditions using Evidence Based Medicine and improving quality of care while reducing costs and LOS.

**Category 1 or 2 expected patient benefits:** Provide incremental specialty care visits ranging from a minimum of 9,359 additional visits in DY 2 to a minimum of 46,794 additional visits by DY5. All supported clinics and sites all accept Medicaid plans and self pay patients.

**Potential indigent population targeted with expansion is incremental specialty care visits approximating:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY2</td>
<td>+ 4,807</td>
</tr>
<tr>
<td>DY3</td>
<td>+ 9,613</td>
</tr>
<tr>
<td>DY4</td>
<td>+12,017</td>
</tr>
<tr>
<td>DY5</td>
<td>+14,420</td>
</tr>
<tr>
<td>TOTAL</td>
<td>= 40,857 or 26% of incremental visits projected.</td>
</tr>
</tbody>
</table>

**Category 3 outcomes:**

Congestive Heart Failure 30 day readmission rate
Acute Myocardial Infarction (AMI) 30 day readmission rate

**Project Description:**

Baptist Health System will **improve care access** for our community population by increasing access to specialty care providers.

The **goals of this project** will be to increase access to specialty care providers by

1. adding additional specialty care offices/clinics
2. adding additional physician providers and
3. otherwise increase availability and choice for our community to manage their health in an appropriate setting when accessing a specialty care provider.

Through Baptist Managed Service Organization Clinics and supporting our hospitals with recruitment/relocation of providers targeting underserved areas, Baptist will continue to recruit specialists to meet the critical access shortages in Bexar County.

This project will allow San Antonio to augment our primary care delivery platform by increasing specialists that (1) meet the shortage needs of our area particularly for the underinsured and (2) increase provider availability to shorten time to treatment for both prevalent acute and chronic conditions, while expanding access to preventive and health maintenance care. With expanded access overall, health will be improved and cost of healthcare reduced. This will also reduce the use of the ER and will improve population health particularly related to the chronic diseases that are high need in RHP6- including diabetes and cardiac disease.

There are **multiple challenges** to this issue including: identification and engagement of those in need, resourcing of initiatives, identification and incentivization of providers to serve this population, and the members of this population taking ownership for their own health needs. BHS will meet these challenges by recruiting specialists dedicated to improving the care provided to our RHP population and to their specific needs where specialty care is severely needed. BHS will also provide our MSO physicians with valuable tools such as Crimson for monitoring and improving our performance in managing the health of our patients.

The **five year expected outcome** is that by increasing specialty care sites and providers, Baptist will meet community/population needs of improving access to specialty care especially in cardiac disease, behavioral health and maternal/pediatric health. Disease prevention will be increased by improved access to care and both acute and chronic conditions will be better managed, when indicated, by improved access to specialists and early interventions. These outcomes will be achieved by accomplishing the project goals noted above.

This **project meets the RHP Regional Goals:**

- Triple Aim: assuring patients receive high-quality, patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth
RHP 6 Community Needs assessment shows that Texas scored “weak” on clinical care areas of diabetes, heart disease and respiratory measures. We will recruit cardiology specialties and neurosciences specialties as two critical examples. These actions meet both “triple Aim” goals as well as match our Community Needs.

The Community Needs Assessment also shows that Texas ranks far below the national average in number of mental health professionals per 100,000 residents. Almost every county in RHPA is designated as a HPSA for mental health. Baptist will recruit additional psychiatrists including psychiatric hospitalists.

RHP 6 Needs also focus on Maternal and Child Health issues and Baptist will recruit and or expand access to medical providers for these specialty areas.

In summary, this project meets the following RHP identified Community Need Goals:

- CN.1 Texas ranks last in the nation on health care quality
- CN.2 A higher prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.
- CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.
- CN.5 Lack of inter-conceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.

In the implementation of this project, Baptist will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, Baptist will ensure that all MSO specialty clinics make ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for specialty care providers.

Through BHS Operational improvement Office, BHS staff will use P-3 Quality Improvement Milestone to further enhance the PI impact on improving care, quality and cost for our patients.

Starting Point/Baseline:

BHS MSO had **92,590** patient visits in existing 20 Specialty Care Sites for Calendar year ending 12–31-11 which will be the baseline and **94,586** Hospitalists visits for a total of **187,176** patient visit encounters. Adding or supporting new locations and providers will increase patient access and number of patient visits beginning 1-1-2012.

We will track both the # of new locations opened/supported after 1-1-2012 and the incremental patient visits/encounters performed annually in these locations and will report increased visits > 187,176. As Baptist assists other physicians/practices with relocating incremental specialty care providers to Bexar County, that impact will be included as accretive to the community.

Rationale:

This project was selected for focus on the critical provider shortages cited in the Community Needs Assessment as well as there is a demonstrated need in BHS hospitals' primary service area for
additional physician specialists Carnahan 2011 needs assessment. As examples cardiac care alone indicates +108 providers, Psychiatry +79 and for Pediatric related specialties there is a need of +301 specialty providers. All specialties are detailed in the Carnahan report.

BHS will expand specialty care access with goals of prevention and health maintenance through health care organizations and through establishment of alternative health care delivery channels. These partnerships and new alternative delivery channels will be enhanced through new locations, new platforms and expanded hours in conjunction with and in addition to BHS supported primary care practices.

This project is aligned with the Triple AIM Goals:
- Increases access for all patients including Medicaid and uninsured patients
- Increasing access to physicians and specialists improves patient outcomes through chronic disease management and earlier intervention for acute conditions
- Eliminates inappropriate and costly use of Emergency Room visits

The core components of the project are:
(a) Increase service availability
(b) Increase number of specialty clinic locations
(c) Implement transparent, standardized referrals across the system
(d) Conduct quality improvement for project

This project also aligns with the RHP 6 Community Needs Assessment by improving access, outreach and care for the areas’ underserved and chronically diseased patient population.
- RHP 6 is expected to have 6% population growth with Bexar County up to 15% growth between 2010-2015; and Texas ranks 45th in the nation in # of physicians per capita. Increasing access improves disease prevention, patient outcomes through chronic disease management and earlier intervention for acute conditions
- Eliminates inappropriate and costly use of Emergency Room visits
- Addresses chronic disease states where health ratings are poorest in Texas as noted above in project narrative

This project certainly is in accord with national initiatives such as Accountable Care organizations. This project meets ALL of the Community needs CN.1, CN.2, CN.3, CN.4, and CN.5 as detailed above.

Related Category 3 Outcome Measure(s):

IT- 3.2 Congestive Heart Failure 30 day readmission rate (Stand Alone Measure)
IT- 3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Stand Alone Measure)
Cardiovascular disease is the largest cause of preventable death in Texas in RHP6. Texas is rated “weak” in heart disease.

By adding Cardiac and other specialty providers, Baptist can provide cardiac interventions and chronic disease management improving the cardiac health of Bexar County. This includes evidence based strategies including CHF Navigator, relationships with post-acute care providers with active CHF and cardiac management programs. Adding specialty providers aids our Primary care provider base and patient population in establishing medical homes that address their health needs.
**Relationship to other Projects:**

This project would have the added advantage of supporting these additional Category 1 and 2 projects:

2.1 Enhance/Expand Medical Homes
2.2 Expand Chronic Care Management Models
2.5 Redesign for Cost Containment
2.7 Implement Evidence Based Disease Prevention Programs
2.10 Use of Palliative Care Programs

Expanding Specialty Care access also supports the patient population focused Category 4 improvements in:

RD-1 Potentially Preventable Admissions
1. Congestive Heart Failure Admission rate
2. Diabetes Admission rate
3. Behavioral Health and Substance Abuse Admissions
4. Chronic Obstructive Pulmonary Disease Admission rate
5. Hypertension Admission Rate

RD-2 30 day readmissions
1. Congestive Heart Failure Admission rate
2. Diabetes Admission rate
3. Behavioral Health and Substance Abuse Admissions
4. Chronic Obstructive Pulmonary Disease Admission rate
5. Stroke

**Relationship to Other Performing Providers’ Projects in the RHP:**

University, Baptist, and Methodist systems have all cited expanding specialty care as a DSRIP Initiative. Per the Carnahan 2011 Needs Assessment for Bexar and surrounding counties, there is a critical need for additional providers in all of the areas and our community should be well served by all of this active recruitment and expansion.

**Plan for Learning Collaborative:**

Following completion of RHP plan, University Health System (anchor) will facilitate formation of working groups of performing providers pursuing similar projects. These working groups will develop a learning collaborative structure which may include goals, meetings, site visits, conference calls, communication plan development, a learning event, and adopt metrics to measure success.

**Project Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, Baptist took into account the extent to which the expansion of specialty care would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The expansion of specialty care clinics and providers will help address a substantial need in the community for increased access to specialty care. It also advances the Waiver goal of improving...
outcomes while curbing the risk of healthcare costs, because early intervention and chronic disease management are cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th>Pass 1</th>
<th>A-D</th>
<th>1.9.2 IMPROVE ACCESS TO SPECIALTY CARE: EXPAND SPECIALTY CARE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
<td>TPI - 159156201</td>
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<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>159156201.3.2</th>
<th>159156201.3.3</th>
<th>3.IT-3.2</th>
<th>3.IT-3.5</th>
</tr>
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<tbody>
<tr>
<td>Congestive Heart Failure 30 day readmission rate</td>
<td>Acute Myocardial Infarction (AMI) 30 day readmission rate</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Pass 1 Estimated Milestone Bundle Amount: $2,416,755</th>
<th>Year 2 Estimated Milestone Bundle Amount: $2,416,755</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,636,550</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,644,214</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,184,351</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1</td>
<td>[P-11] Establish or expand existing specialty care clinic</td>
<td>Metric 1 [P-11.1]: # of patients served by new or expansion of specialty care and hospitalists in new sites or by new providers Baseline is 187,176 annual visits 12/31/2011 and the DY2 goal will be an increase of 5% over baseline for year ending 9/30/2013 by adding new sites and new providers. Data Source: BHS Financial Records</td>
<td>Year 2 Estimated Milestone Bundle Amount: $2,416,755</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,636,550</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,644,214</td>
</tr>
<tr>
<td>Milestone 2</td>
<td>[P-11] Establish expand existing specialty care clinic</td>
<td>Metric 1 [P-11.1]: # of patients served by new or expansion of specialty care and hospitalists in new sites or by new providers Baseline is 187,176 annual visits 12/31/2011 and the DY2 goal will be an increase of 10% over baseline for year ending 9/30/2014 by adding new sites and new providers. Data Source: BHS Financial Records</td>
<td>Milestone 2 Estimated Incentive Payment: $2,636,550</td>
<td>Milestone 3 Estimated Incentive Payment: $2,644,214</td>
<td>Milestone 4 Estimated Incentive Payment: $2,184,351</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,416,755</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,636,550</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,644,214</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,184,351</td>
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</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,881,871
Identifying Project and Provider Information:

Title: 1.10.1 Enhance improvement capacity within people
Unique RHP ID#: 159156201.1.3 – PASS 1
Performing Provider: VHS San Antonio Partners, LLC d/b/a Baptist Health System
Performing Provider TPI: 159156201

Project Summary:

Provider Description: Baptist Health System includes five acute- (Baptist Medical Center (623 beds), Mission Trail Baptist Hospital (110 beds), North Central Baptist Hospital (280 beds), Northeast Baptist Hospital (379 beds), and St. Luke’s Baptist Hospital (282 beds)) which offer 1,674 licensed beds. In 2011, Baptist Health System was recognized by U.S. News and World Report for earning more, high performing specialty rankings (5) than any other health system in the San Antonio metropolitan area. All five hospitals have earned Accredited Chest Pain Center designation, as well as Primary Stroke Center Certification. Medicare has designated each as Texas’ only Medicare Value Based Care Centers. The system also includes Baptist Regional Children’s Center, Baptist Breast Center, HealthLink wellness and fitness center, Baptist M&S Imaging Centers, community health and wellness programs, ambulatory services, rehabilitation services, air medical transport, School of Health Professions, and other health-related services and affiliations. It is part of the Nashville, Tennessee-based Vanguard Health Systems.

Intervention(s): This project will establish and staff an office of Operational Improvement. We will train Baptist staff and physicians on Lean and other Process Improvement (PI) tools. Using trained staff and a variety of PI tools, we will improve efficiencies and reduce variation in care processes resulting in improvement in quality measures and reduced costs.

Need for the project: The Institute of Medicine (IOM) states that the majority of medical errors result from faulty systems and processes, not faulty individuals. Enhanced staff training and focus on tools to improve processes, reduce waste, and eliminate variation in care all contribute to Triple Aim goals of improving patient flow and increasing access for all patients, a more coordinated care delivery system and improving patient safety and quality while reducing costs.

This project also ENABLES 2.8 which is the practical application of these tools to improve efficiency and quality.

Target population: The specific target population is Baptist employed staff and both employed physicians as well as other medical staff leaders. By training staff with tools to improve processes, eliminate waste and reduce variation in care we are not only improving the quality of care provided to our patients but also creating increased access to care through reduced LOS, reduction in barriers in throughput all of which benefits the residents of Bexar County needing access to acute care.

Category 1 or 2 expected patient benefits: With at least 128 employees/physicians trained in PI tools by end of DY3 and at least five improvement projects completed each year, by DY 4 and 5, we will have measureable improvement in patient quality measures from our Scorecard such as reduction in readmissions, reductions in hospital acquired conditions and reduction in falls. All of these quality improvements are direct benefit to the patients treated in Baptist hospitals and other entities. Over 26% of BHS’ Inpatient population is Medicaid or Uninsured indigent and another large % have Medicaid supplemental to Medicare. Over 43% of BHS’ Outpatient population is Medicaid or Uninsured indigent and another large % have Medicaid supplemental to Medicare. The impact of staff training to yield quality and cost improvements through standardization while reducing variation will greatly benefit this patient population.

Category 3 outcomes:
Congestive Heart Failure 30 day readmission rate  
Acute Myocardial Infarction (AMI) 30 day readmission rate  

**Project Description:**

BHS proposes the implementation of lean and six sigma performance improvement methodology to improve safety, quality, and efficiency. Sigma six is a widely accepted clinical methodology to improve the quality and efficiency of the delivery of healthcare services. Baptist will implement sigma six in Category 1 Project 10.1 Enhance Performance improvement capacity within people, which will ENABLE Category 2 Project 8 Apply process improvement methodology to improve quality/efficiency. Various tools will be used to drive continuous improvement including, but not limited to, FMEA (failure mode evaluation analysis) value stream mapping, process mapping, identification and elimination of waste and non-value added processes via direct observation and data collection.

The **goals** of this project are

1. Establish and staff an office of Operational improvement
2. Train BHS staff and physician on lean and other PI tools
3. Use trained staff and array of PI tools to improve efficiencies and reduce variation in care processes to drive improvement in quality measures

Various **challenges** faced by BHS during this implementation include educating a large number of staff on lean, changing the way problems are approached and improved upon, empowering front-line staff to identify opportunities for improvement along with capturing their ideas to make the improvement, and the significant amount of variation that exists within BHS and all healthcare processes.

To address these challenges, BHS proposes a performance improvement infrastructure to educate employees on lean and performance improvement tools. Training is accomplished through various avenues including a four day lean practitioner training where employees are trained on lean principles and tools and how to apply them to a live project through their training. In addition, targeted training sessions will focus on transferring knowledge to employees and physicians on how to identify and eliminate waste.

BHS will track all trained staff along with their individual knowledge of specific lean tools with the goal of developing teachers and lean leaders. BHS will track all performance improvement activity in a project tracking application that tracks project details including metrics impacted and staff involvement.

The **five year goals** are to have a substantial workforce that is trained and using various PI tools in approaching work and cost efficiencies, reducing variation in processes while improving clinical care, patient outcomes and improving the total patient experience.

This **project meets the RHP Regional Goals:**

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
• Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
• Further develop and maintain a coordinated care delivery system
• Improve outcomes while containing cost growth

This project meets the following RHP identified Community needs:
CN.1 Texas ranks last in the nation on health care quality
CN.2 A higher prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.

BHS Operational improvement Office will use P-3 Quality Improvement Milestone to further enhance the PI impact on improving care, quality and cost for our patients.

Starting Point/Baseline:
An Operational Improvement Department has been formed to support the lean deployment for BHS. This department consists of a Vice President of Operational Improvement and Operational Improvement Engineers trained and certified in lean and/or six sigma. As of September 2012 there are 71 BHS employees trained as lean practitioners. The source for this information is the BHS lean practitioner employee roster maintained in the Operational Improvement Department at BHS.

Rationale:
Having an office responsible for performance improvement will increase the improvement capacity in BHS by championing the knowledge transfer of lean and other quality improvement tools to BHS staff. Ongoing training by the office of Operational Improvement will increase the capacity for performance improvement activities on a continuous basis.

Capturing employee ideas for improvement through an employee suggestion mechanism and implementing those ideas fosters a culture of continuous improvement. Encouragement of continuous improvement throughout all levels of the organization will accelerate the lean culture change that promotes employee empowerment to encourage change for improvement

This project’s Core Components are:
(a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture.
(b) Develop an employee suggestion system that allows for identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
(c) Continuous Quality Improvement. BHS recognizes that a substantial part of this project is geared towards enhancing quality improvement—in fact the entire project is the implementation of one comprehensive quality improvement methodology. In addition BHS will Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects as listed in P-3 of the quality improvement milestones of the DSRIP Menu.

This project is aligned with the Triple AIM Goals:
- Improving patient flow and infrastructure processes increases access for all patients including Medicaid and uninsured patients
- Improving flow and processes contributes to a more coordinated delivery system
- Improving flow and processes, reducing variation and increasing care reliability improves patient safety and outcomes and reduces costs, eliminating waste from system

This project also aligns with the RHP 6 Community Needs Assessment by improving access, outreach and care for the areas’ underserved, diseased patient population by equipping BHS leaders and staff with PI tools and knowledge to improve patient flow and increase access to care. This project addresses CN1 and CN2 as detailed above.

This project is directly in accord with national initiatives such as Accountable Care organizations.

**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT 3.2</td>
<td>Congestive Heart Failure 30 day readmission rate</td>
</tr>
<tr>
<td>IT 3.5</td>
<td>Acute Myocardial Infarction (AMI) 30 day readmission rate</td>
</tr>
</tbody>
</table>

Cascading performance training tools to front line leadership and staff employees as well as the establishment of the employee suggestion line, will better position our organization’s clinical and non-clinical staff to evaluate current treatment plans, patient education, discharge tools and transitional care methods for the above clinical conditions and to work intra departmentally, with medical staff and with other providers to redesign and improve the care process for potentially preventable readmissions.

Cardiovascular disease is the largest single cause of death in Bexar County. Improving internal and transitional care and patient education through staff working knowledge and utilization of PI tools will assist BHS in reducing readmission rates for the above cardiac conditions and improve population health.

**Relationship to other Projects:**

The project is a direct link to 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency. Lean tools can be utilized to improve cycle times in facilities/clinics and improve patient flow and experience by identifying constraints, wastes, and non-value-added steps from the patient’s perspective.

This project supports Texas Waiver 1115 and Triple Aim goals to improve outcomes while containing cost growth. Lean is utilized to improve outcome via the identification and elimination of waste in processes. These tools focus on reducing undesirable variation in clinical practices which supporting Triple Aim concept of optimizing the health system and system integration.

Additionally, this process and education enables many of the improvements to be made in Category 4:

- RD-1 Potentially Preventable Admissions
- RD-2 30 Day Readmissions
- RD-3 Potentially Preventable Complications
- RD-5 Emergency Department
<table>
<thead>
<tr>
<th><strong>Relationship to Other Performing Providers’ Projects in the RHP:</strong></th>
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</thead>
<tbody>
<tr>
<td>None identified.</td>
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<table>
<thead>
<tr>
<th><strong>Plan for Learning Collaborative:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Project Valuation:</strong></th>
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<tbody>
<tr>
<td>Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing this project, Baptist took into account the extent to which A performance Improvement culture meets the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project. The implementation of a lean and six sigma performance improvement methodology will help address a substantial need in the community for increased efficiency and quality of care. These efficiencies will translate to lower costs of care and ultimately increased access for more patients in the community.</td>
</tr>
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### 1.10.1 Enhance Improvement Capacity within People

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome</th>
<th>Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>159156201.3.4</td>
<td>3.IT-3.2</td>
<td>Congestive Heart Failure 30 day readmission rate</td>
</tr>
<tr>
<td>159156201.3.5</td>
<td>3.IT-3.5</td>
<td>Acute Myocardial Infarction (AMI) 30 day readmission rate</td>
</tr>
</tbody>
</table>

#### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
[P-1.1] Establish a performance improvement office

**Metric 1 [P-1.1]:** Documentation of performance improvement office including system leader and PI team members as well as training tools deployed

**Goal:** Setting up the personnel and infrastructure necessary to activate the project.

**Data Source:** BHS HR documents, Policies and Procedures

**Milestone 1 Estimated Incentive Payment:** $758,198

#### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 2**
[P-2] Establish a program for trained experts on PI to mentor and train other staff, including front line staff, for safety and quality care improvement.

**Metric 2 [I-2.2]:** Conduct at least 5

#### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4**
[P-2] Establish a program for trained experts on PI to mentor and train other staff, including front line staff, for safety and quality care improvement.

**Metric 1 [P-2.2]:** Train the trainer program established

**Baseline/Goal:** Baseline is 107 trained at year ending 9/30/2013. Goal is 128+ by 9/30/14.

**Data Source:** BHS lean practitioner employee roster the BHS Operational Improvement Department

**Milestone 4 Estimated Incentive Payment:** $1,244,336

#### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 8**
[I-9] Demonstrate improvement in

**Milestone 7**
[P-2] Establish a program training experts on PI to mentor and train other staff, including front line staff, for safety and quality care improvement.

**Metric 1 [P-2.2]:** Conduct at least 5 improvement projects led by staff within 6 months of their training

**Baseline/Goal:** Baseline is 10 implemented by 9/30/14. Goal is 5 additional projects by 9/30/15.

**Data Source:** BHS Operational Improvement Department Project Tracking documents

**Milestone 7 Estimated Incentive Payment:** $1,027,930

**Milestone 6**

**Data Source:** BHS Operational Improvement Department Project Tracking documents

**Milestone 5 Estimated Incentive Payment:** $1,244,336
<table>
<thead>
<tr>
<th>Metric 1 [P-2.2]</th>
<th>[I-8.1]</th>
<th>Metric 1 [I-9.1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train the trainer program established-increase # of employees and/or physicians trained by 50%</td>
<td>Submission of quality dashboard or scorecard</td>
<td>Improvement in selected quality measures</td>
</tr>
<tr>
<td>Baseline/Goal: Baseline is 71 trained at the year ending 9/30/2012. Goal is 100+9/30/13.</td>
<td>Goal: The goal is to set up a process and methodology to monitor quality.</td>
<td>Data Source: BHS Operational Improvement Department Project Tracking documents</td>
</tr>
<tr>
<td>Data Source: BHS lean practitioner employee roster in the BHS Operational Improvement Department</td>
<td>Data Source: Copies of BHS Monthly Dashboard/Scorecard</td>
<td>Data Source: BHS Monthly Dashboard/Scorecard</td>
</tr>
</tbody>
</table>

**Milestone 2**
- Estimated Incentive Payment: $758,198

**Milestone 3**
- [I-8] Establish a quality dashboard or scorecard to be shared with organizational leadership at all levels of the organization on a regular basis including outcome and patient satisfaction measures

**Milestone 4**
- Estimated Incentive Payment: $2,481,459

**Milestone 5**
- [I-9] Demonstrate improvement in 2 Quality measures

**Milestone 6**
- Estimated Incentive Payment: $1,244,336

**Milestone 8**
- Estimated Incentive Payment: $1,027,930
<table>
<thead>
<tr>
<th>Milestone 3 Estimated Incentive Payment: $758,197</th>
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<td>Year 2 Estimated Milestone Bundle Amount: $2,274,593</td>
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<tr>
<td>Year 3 Estimated Milestone Bundle Amount: $2,481,459</td>
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<tr>
<td>Year 4 Estimated Milestone Bundle Amount: $2,488,672</td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $2,055,860</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,300,584**
Identifying Project and Provider Information:

Title: 1.9.2 Improve access to specialty care: Pediatric Subspecialty Expansion
Unique RHP ID#: (TPI Pending).1.1 – PASS 1
Provider Name: Children’s Hospital of San Antonio
TPI: 020844903

Project Summary:

Provider Description: Children’s Hospital of San Antonio (CH of SA) is a 249 bed academic children’s hospital serving San Antonio, New Braunfels, the Southern and Western boarders of Texas, as well as the Central Texas hill country.

Intervention(s): The primary goal of this objective is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services.

Need for the project: On September 21, 2012, CH OF SA Santa Rosa Children’s hospital converted to a free-standing children’s hospital and is now officially called Children’s Hospital of San Antonio. This was the first step toward creating a Tier 1 Children’s hospital, which will be the focal point for a network of pediatric services. This project will enable CH of SA to create the much needed geographically dispersed network of pediatric specialty care services throughout the community.

Target population: This project will target the pediatric population, ages 0 – 17, which currently account for more than 26% of the total population. In Bexar and Comal counties, an estimated 14% of the population is covered by Medicaid or indigent. Increasing subspecialty care access for this population can significantly improve patient health outcomes, patient satisfaction, utilization patterns and help to reduce healthcare costs.

Category 1 or 2 expected patient benefits: CH of SA converted to a free-standing children’s hospital in September 2012 and is in the process of developing a network of pediatric services with its new Academic partner. The goal of this project is to increase access to subspecialty care by adding 1 new subspecialty care clinic in DY2, 1 in DY3, 1 in DY4 and 1 in DY5. This benefit to patients is reflected in our milestones. Furthermore, this project will enable CH of SA to increase the number of subspecialist by 4 in DY3, 3 in DY4, and 3 in DY5. With each new clinic, CH of SA estimates patient visits to be 1,000 in DY3, 1,500 patient visits in DY4, and 2,000 patient visits in DY5. CH of SA expects that approximately 20% of the patients served in these new clinics will be Medicaid or indigent.

Category 3 outcomes: [IT-9.2] The goal is to reduce pediatric emergency department visits in DY4 and DY5. Targets will be determined based on the baseline established in DY3.

Project Description:

Children’s Hospital of San Antonio (CH of SA) will create a free-standing, Tier 1 Children’s hospital, which will be the focal point for a network of pediatric services throughout the community. As part of this network, CH of SA will improve the access to sub-specialty care by establishing practices and creating clinics and other sites of services to improve access to care for children with subspecialty healthcare needs. Additionally, CH of SA will serve as an aggregator where needed or desired to bring smaller practices together to improve efficiencies in care delivery models and further expand access points.

Goals and Relationship to Regional Goals:

Project Goal:
The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services. Targeted specialties include, but are not limited to:

- Pediatric Neurosurgery
- Otolaryngology
- Orthopedics
- Surgery
- Cardiology
- Nephrology
- Plastic Surgery
- Endocrinology
- Gastroenterology

This project meets the following regional goals:

- Triple Aim: assuring patients receive high-quality, patient-centered care, in the most cost effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

**5-Year Expected Outcome for Provider and Patients:**

Children’s Hospital of San Antonio expects to increase the number of specialty care clinics by 4, and 10 new pediatric specialists from the targeted list of specialties over the next five years. This increase will result in more available appointment times, increased patient awareness of available services, improved patient health outcomes, improved patient satisfaction, improvement in utilization patterns, and reduction in cost of services.

In the implementation of this project, CH of SA will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, CH of SA will ensure that all specialty care clinics make ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for specialty care clinics.

**Starting Point/Baseline:**

According to 2010 3d Health physician need study, Shortage of 20 pediatric sub-specialists in S.A. MSA; limited number of sites of care – most are congregated near the acute care facilities rather than spread across the region.
**Rationale:**

As stated in the RHP Community Needs Assessment, chronic disease management (CN.2) and provider shortages (CN.3) are major issues facing the region. Furthermore, recent data indicates that the San Antonio MSA has an estimated deficit of 20 Pediatric Subspecialists. This deficit is projected to intensify over the coming years due to physician retirements and increased demands from growth in the 00 to 18 age cohort.

Additionally, current conditions in Bexar county are not conducive for retaining and attracting the base of pediatric specialists needed to serve the current population. By creating a free-standing, Tier 1 children’s hospital, CH of SA is well positioned to help fill the gaps in pediatric sub-specialty care.

This project will include the following components:

- **a) Increase service availability with extended hours:** a broad network of specialists will be established through this program, which will allow for improved access to pediatric specialists and the opportunity to expand hours of care in selected locations as necessary.

- **b) Increase number of specialty clinic locations:** the proposed plan is to develop a broad based network of specialty clinics, which will improve access throughout the geographic market and to leverage more limited pediatric specialists through rotations to various clinic sites.

- **c) Implement transparent, standardized referrals across the system:** the proposed network will use a common information system and scheduling process to minimize delays in scheduling specialty visits and to assure that patients can access needed specialists in the right location wherever they may be located.

- **d) Quality Improvement for project using methods such as rapid cycle improvement.** Activities may include, but are not limited to, identifying project impacts, and identifying “lessons learned.” Network performance metrics to include scheduling issues, patient satisfaction issues and specialty physician needs will be monitored using the common network information system. Any identified performance gap will be addressed on a real time basis to ensure that the network is functioning at the highest levels to achieve the Trip Aim: improved access, quality and outcomes.

Three major milestones were selected to ensure that this project achieves the intended results:

1) **Conduct specialty care gap assessment based on community need:** this will establish which specialties should be targeted

2) **Launch/expand a specialty care clinic:** This will address the needs of the community thereby improving access to specialty care services.

3) **Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties:** this is a necessary element to improving overall access to specialty care.

**Unique community need identification numbers the project addresses:**

- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

- CN.2 - High prevalence of chronic disease and related health disparities require greater
prevention efforts and improved management of patients with chronic conditions.

- CN.3 - Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

On September 21, 2012, CH OF SA Santa Rosa Children’s hospital converted to a free-standing children’s hospital and is now officially called Children’s Hospital of San Antonio. This was the first step toward creating a Tier 1 Children’s hospital, which will be the focal point for a network of pediatric services. This project will enable Children’s Hospital of San Antonio to create the much needed geographically dispersed network of pediatric specialty care services throughout the community.

**Related Category 3 Outcome Measure(s):**

OD-9, right Care, Right Setting:

IT-9.2 – Appropriate ED Utilization
  - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)

**Reasons/rationale for selecting the outcome measure:**

The emergency department frequently becomes the focal point in the health care system when care is poorly coordinated. With shortages in many pediatric specialties, chronic disease management is a critical area of concern due to the impact it can have on ED utilization. The primary objective of this project is to improve access by establishing pediatric specialty practices, clinics and other sites of services. By providing a more geographically dispersed network of specialty care, patients with chronic diseases will have greater access to these much needed services, which will reduce ED utilization. For this reason, improvement target IT-9.2, ED appropriate utilization will be used as an improvement measure for this project.

**Relationship to other Projects:**

Expanding pediatric specialty care supports/reinforces several of the Category 1 and 2 projects: By increasing the number of pediatric sub-specialist and clinics, patients will have better access to providers who are equipped to manage their chronic diseases (project 1.3 & 2.2); this project will also support projects (2.1) Enhance/Expand Medical Homes, as it will give providers participating in medical home better access to specialty care for their patients; and ultimately, this project reinforces the objective of (2.4) Redesign to Improve the Patient Experience.

Additionally, this project will support each of the population focused improvements in Category 4: RD-1, Potentially Preventable Admissions; RD-2, 30 day re-admissions; RD-3, Potentially Preventable Complications; and RD-4; Patient-Centered Healthcare

**Relationship to Other Performing Providers’ Projects in the RHP:**

University Health System
Baptist Medical Center
Methodist
Plan for Learning Collaborative:

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

Project Valuation:

The valuation of CH OF SA projects use a method which ranks the importance of each project based several key factors. First, CH OF SA considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CH OF SA considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CH OF SA reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The pediatric population often requires subspecialists in order to adequately address the unique needs of this population. Therefore, the expansion of specialty pediatric care will meet the Waiver goal to increase access to appropriate care by helping address a substantial need in the community for increased access to specialty care. This increase in access will also lead to better health outcomes for this vulnerable population, and ultimately increased efficiency of healthcare resources as the population becomes less reliant on EDs to receive appropriate care.
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<th>(TPI Pending).1.1 PASS 1</th>
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<tr>
<td><strong>Milestone 1</strong> P-1: Conduct specialty care gap assessment based on community need. Metric 1 P-1.1: Documentation of gap assessment. Baseline: establish Baseline for recruitment Data Source: Needs Assessment</td>
<td>Milestone 2 P-11: Launch/expand a specialty care clinic based on identified need from assessment Metric 1 P-11.1: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic Milestone 3 Estimated Incentive Payment $1,122,065</td>
<td>Milestone 4 I-22: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 I-22.1: Increase number of specialist providers, Milestone 5 Estimated Incentive Payment: $1,224,113</td>
<td>Milestone 7 P-11: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic Milestone 6 I-22: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 I-22.1: Increase number of specialist providers, Milestone 8 Estimated Incentive Payment: $1,014,163</td>
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<td><strong>Milestone 2</strong> P-11: Launch/expand a specialty care clinic based on identified need from assessment Metric 1 P-11.1: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic</td>
<td>Milestone 3 P-11: Launch/expand a specialty care clinic based on identified need from assessment Metric 1 P-11.1: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic Milestone 4 Estimated Incentive Payment: $1,224,113</td>
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<td>Milestone 5 P-11: Launch/expand a specialty care clinic based on identified need from assessment Metric 1 P-11.1: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic Milestone 5 Estimated Incentive Payment: $1,227,671</td>
<td>Milestone 7 P-11: Launch/expand a specialty care clinic Goal: 1 Data Source: Documentation of new/expanded specialty care clinic Milestone 6 Estimated Incentive Payment: $1,014,163</td>
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<td>Milestone 8 I-22: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 I-22.1: Increase number of specialist providers,</td>
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**Year 2 Estimated Milestone Bundle Amount:** $2,244,130

**Year 3 Estimated Milestone Bundle Amount:** $2,448,225

**Year 4 Estimated Milestone Bundle Amount:** $2,455,342

**Year 5 Estimated Milestone Bundle Amount:** $2,028,326

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $9,176,023
**Identifying Project and Provider Information:**

| Title: 1.1.1 – Establish more primary care clinics: Primary Care Expansion Program |
| Unique RHP ID#: (TPI Pending) 1.2 – PASS 1 |
| Provider Name: Children’s Hospital of San Antonio |
| TPI: 020844903 |

**Project Summary:**

Provider Description: Children’s Hospital of San Antonio (CH of SA) is a 249 bed academic children’s hospital serving San Antonio, New Braunfels, the Southern and Western boarders of Texas, as well as the Central Texas hill country.

Intervention(s): The primary goal of this objective is expand the capacity of primary care by developing a geographically dispersed network of pediatric primary clinics throughout San Antonio.

Need for the project: On September 21, 2012, CH OF SA Santa Rosa Children’s hospital converted to a free-standing children’s hospital and is now officially called Children’s Hospital of San Antonio. This was the first step toward creating a Tier 1 Children’s hospital, which will be the focal point for a network of pediatric services. This project will enable CH of SA to create the much needed geographically dispersed network of pediatric primary care services throughout the community.

Target population: This project will target the pediatric population, ages 0 – 17, which currently account for more than 26% of the total population. In Bexar and Comal counties, an estimated 14% of the population is covered by Medicaid or indigent. Increasing primary care access for this population can significantly improve patient health outcomes, patient satisfaction, utilization patterns and help to reduce healthcare costs.

Category 1 or 2 expected patient benefits: Working with its new academic partner, CH of SA seeks to enhance primary care capacity for the Medicaid and the indigent population by adding new clinics and hiring new physicians to serve the community. To accomplish this, CH of SA will open 1 clinics in DY2, 2 in DY3, 2 in DY4 and 2 in DY5. Furthermore, it will hire 1 new pediatrician in DY2, 2 in DY3, 2 in DY4, and 2 in DY5. With each new clinic, CH of SA estimates that it will have the ability to offer 1,170 urgent care appointments in DY 4 and an additional 810 in DY 5. CH of SA expects that approximately 20% of the patients served in these new clinics will be Medicaid or indigent.

Category 3 outcomes: [IT-9.2] The goal is to reduce pediatric emergency department visits in DY4 and DY5. Targets will be determined based on the baseline established in DY3.

**Project Description:**

Children’s hospital of San Antonio (CH of SA) will develop a geographically dispersed network of pediatric primary care clinics throughout Bexar County to enhance access points, increase available appointment times, and promote patient awareness of available services and overall primary care capacity, all of which will ultimately result in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Recent physician demand analysis indicates a shortage of over 100 primary care physicians in the San Antonio area. Due to the growth of the population and impending physician retirements,
this deficit is likely to grow in the coming years. The primary focus will be on the expansion of Pediatric practices, pediatricians, but could also include mid-level providers and Family Medicine practices

**Goals and Relationship to Regional Goals:**

**Project Goal:**

The primary goal of this objective is to expand the capacity of Pediatric primary care to better accommodate the needs of children in the community. Increased access to primary care allows patients to receive the right care at the right time in the right setting. This will be accomplished by:

- Assisting established practices with new expansion and replacement of retiring physicians.
- Adding new practices in areas with significant access issues
- Serving as an aggregator where needed or desired to bring smaller practices together to improve efficiencies in care delivery models.

This project meets the following regional goals:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

**5-Year Expected Outcome for Provider and Patients:**
Children’s Hospital of San Antonio expects to increase the number of primary care access points by at least 7 new clinics over the next five years. This increase will result in more available appointment times, increased patient awareness of available services, improved patient health outcomes, improved patient satisfaction, improvement in utilization patterns, and reduction in cost of services.

In the implementation of this project, CH of SA will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, CH of SA will ensure that all pediatric primary care clinics make ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for pediatric primary care clinics.

**Starting Point/Baseline:**
According to the 2010 3d Health assessment, there is a shortage of 40 Pediatricians in Bexar County.

**Rationale:**
In the current health care system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be better managed in a primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. To further complicate matters, Texas has a growing shortage of primary care doctors due to a decline in the number of medical students choosing to go into primary care. The recent community needs assessment identified healthcare provider shortages as a major issue facing RHP 6. With 26% of the population under the age of 18 and projected future growth of this age cohort over the next five years, access to pediatric primary care will only intensify.

The primary objective of this project is to establish more pediatric primary care clinics and practitioners in order to expand access to pediatric primary care.

**Three major milestones were selected to ensure that this project achieves the intended results:**

1. Establish additional/expand existing/relocate primary care clinics: this will be a critical factor to increasing pediatric access to primary care.
2. Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers: this is an equally critical factor to increasing pediatric access to primary care.
3. Enhanced capacity to provide urgent care services in the primary care setting: by increasing access to primary care, patients can access their primary care provider for urgent care services that are appropriate for the primary care setting rather than using the ED.

**Unique community need identification numbers the project addresses:**

- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.2 - High prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.
- CN.3 - Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

On September 21, 2012, CH OF SA Santa Rosa Children’s hospital converted to a free-standing children’s hospital and is now officially called Children’s Hospital of San Antonio. This was the first step toward creating a Tier 1 Children’s hospital, which will be the focal point for a network of pediatric services. This project will enable Children’s Hospital of San Antonio to create the much needed geographically dispersed network of pediatric primary care services throughout the community.
**Related Category 3 Outcome Measure(s):**

OD-9, Right Care, Right Setting:

IT-9.2 – Appropriate ED Utilization

- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)

**Reasons/rationale for selecting the outcome measure:**

According to a recent physician demand analysis, there is an estimated shortage of 40 pediatricians in Bexar County. This shortage of pediatricians can cause significant access issues, forcing parents/guardians to use the ED as their child’s primary care provider for acute illness management and preventative care needs. The primary goal of this project is to help established practices expand, replace retiring physicians, and add new practices in areas with significant access issues. The ED Appropriate Utilization improvement target is an accurate measure for determining the impact this increased access has on ED utilization.

**Relationship to other Projects:**

Expanding pediatric primary care supports/reinforces several of the Category 1 and 2 projects: By increasing the number of pediatricians, patients will have better access to providers who are equipped to manage their chronic diseases (project 1.3 & 2.2); this project will also support projects (2.1) *Enhance/Expand Medical Homes*, as it provide additional pediatricians who could potentially participate in a medical home model; and this project also reinforces the objective of (2.4) *Redesign to Improve the Patient Experience*, in that increased access to primary care will result in greater overall patient satisfaction.

Additionally, this project will support each of the population focused improvements in Category 4: RD-1, *Potentially Preventable Admissions*; RD-2, *30 day re-admissions*; RD-3, *Potentially Preventable Complications*; and RD-4; *Patient-Centered Healthcare*

**Relationship to Other Performing Providers’ Projects in the RHP:**

- University Hospital
- Baptist Medical Center
- Frio Regional Hospital
- Guadalupe Regional Medical Center
- Peterson Regional Medical Center
- Medina Regional Hospital
- Val Verde Regional Medical Center
- University of Texas Health Science Center

**Plan for Learning Collaborative:**

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.
Project Valuation:

The valuation of CH OF SA projects use a method which ranks the importance of each project based on several key factors. First, CH OF SA considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CH OF SA considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CH OF SA reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The expansion of primary care will help address a substantial need in the community for increased access to primary care. It also advances the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes. The positive benefits of preventative primary care are especially prevalent in the pediatric population because many clinical issues can be identified and addresses before they become chronic or even acute conditions.
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**Milestone 1**
P-1: Establish additional/expand existing/relocated primary care clinics.  
**Metric 1 P-1.1:** Number of additional clinics or expanded hours or space  
**Goal:** 1  
**Data Source:** Executed agreements or new primary care schedule

**Milestone 2**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 P-5.1:** Documentation of increased number of providers and staff and/or clinic sites.

**Milestone 3**
P-1: Establish additional/expand existing/relocated primary care clinics.  
**Metric 1 P-1.1:** Number of additional clinics or expanded hours or space  
**Goal:** 2  
**Data Source:** Executed agreements or new primary care schedule

**Milestone 4**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 P-5.1:** Documentation of increased number of providers and staff and/or clinic  
**Goal:** 2

**Milestone 5**
P-1: Establish additional/expand existing/relocated primary care clinics.  
**Metric 1 P-1.1:** Number of additional clinics or expanded hours or space  
**Goal:** 2  
**Data Source:** Executed agreements or new primary care schedule

**Milestone 6**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 P-5.1:** Documentation of increased number of providers and staff and/or clinic  
**Goal:** 2

**Milestone 7**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 P-5.1:** Documentation of increased number of providers and staff and/or clinic  
**Goal:** 2

**Milestone 8**
P-1: Establish additional/expand existing/relocated primary care clinics.  
**Metric 1 P-1.1:** Number of additional clinics or expanded hours or space  
**Goal:** 2  
**Data Source:** Executed agreements or new primary care schedule

**Milestone 9**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 P-5.1:** Documentation of increased number of providers and staff and/or clinic  
**Goal:** 2

**Milestone 1 Estimated Incentive Payment:** $1,294,691  
**Milestone 3 Estimated Incentive Payment:** $1,412,438  
**Milestone 5 Estimated Incentive Payment:** $944,362  
**Milestone 7 Estimated Incentive Payment:** $780,125  
**Milestone 9 Estimated Incentive Payment:** $780,125
| Goal: 1  
Data Source: Executed agreement | Data Source: Executed agreement  
Milestone 4 Estimated Incentive Payment: $1,412,438 | Goal: 2  
Data Source: Executed agreement  
Milestone 6 Estimated Incentive Payment: $944,362 |
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| Milestone 7  
I-13: Enhanced capacity to provide urgent care services in the primary care setting.  
Metric 1 I-13.1: Percent patients receiving urgent care appointment in the primary care clinic.  
Baseline: 8,400 projected primary care clinic visits of which 14% are projected to be urgent.  
Goal: 1,170 urgent care visits  
Data Source: Executed agreements or new primary care schedule | Milestone 7 Estimated Incentive Payment: $944,362 | Milestone 10 Estimated Incentive Payment: $780,125 |
| Milestone 10  
I-13: Enhanced capacity to provide urgent care services in the primary care setting.  
Metric 1 I-13.1: Percent patients receiving urgent care appointment in the primary care clinic.  
Goal: additional 810 (14%) patients receiving urgent care appointments.  
Data Source: Executed agreements or new primary care schedule | Milestone 10 Estimated Incentive Payment: $780,125 |

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### Identifying Project and Provider Information:

| Title: 1.1.2 Expand existing primary care capacity |
| Unique RHP ID#: 020844901.1.1 – PASS 1 |
| Provider Name: CHRISTUS Santa Rosa Health System (CSRHS) |
| TPI: 020844901 |

### Project Summary:

**Provider Description:** CHRISTUS Santa Rosa Health System (CSRHS) is a Catholic, non-profit health and wellness system with three adult acute care hospitals, one short-stay surgical hospital, two free standing emergency departments and several physician joint-venture ambulatory surgery centers. With a combined total of 496 beds, CSRHS currently serves the San Antonio and New Braunfels markets which has a total population of 1.9 million.

**Intervention(s):** This project will expand primary care capacity by increasing the number of primary care clinics, hours and staffing, which will improve overall access for the targeted population.

**Need for the project:** Texas has a growing shortage of primary care providers due to the needs of an aging population. This is especially true for the far Northwest side of San Antonio, which is considered a medically underserved area and has an identified need of 106 primary care physicians. CHRISTUS Santa Rosa Family Health System currently does not have an adequate number of physicians to expand into this service area and will need to add an additional four providers to its practice over the next four years.

**Target population:** The target population for this project lives on the far northwest side of San Antonio, which is currently considered to be a medically underserved area. The total population for this area is estimated to be at 464,000, and 12% of that population is either Medicaid eligible or indigent.

**Category 1 or 2 expected patient benefits:** In the last twelve months, the existing primary care clinic had 29,494 total office visits. The goal of this project is to increase access by offering an additional 4,500 office visits in year four of the program and an additional 3,750 visits in year five. This increase in capacity will provide much needed access to the uninsured, underserved, indigent and Medicaid population. CSRHS expects that approximately 20% of the patients served in this clinic will be Medicaid or indigent.

**Category 3 outcomes:** [IT-9.2] The goal of this project is to improve ED utilization in DY4 and DY5. Targets will be determined based on the baseline established in DY3.

### Project Description:

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 (CN.3) is a critical problem that can be addressed under this waiver. 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. 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 managed population health.
The CHRISTUS Santa Rosa Family Health Center (CSRHC) is a NCQA Level III Patient-Centered Medical Home accredited program providing comprehensive outpatient medical and wellness care to pediatric and adult patients while training physicians in the specialty of Family Medicine. The CSRFHC’s goal is to provide quality, comprehensive, interdisciplinary and multidisciplinary outpatient medical care of varying severity to all patients seeking care in a teaching environment. Additionally, all physicians successfully graduating from this program will be fully trained to operate patient-centered medical homes.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to expand primary care capacity by increasing the number of primary care clinics, hours and staffing, which will improve overall access for the targeted population.

This project meets the following regional goals:
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

5-Year Expected Outcome for Provider and Patients:
CSRHS plans to expand beyond its existing clinic space and add an additional 4 primary care physicians over the next four years. By expanding the number of primary care clinics, physicians, hours and staffing, this project will result in a decrease in the number of patients that receive services in urgent and emergency settings, therefore resulting in improvement in the overall health of the population and reduction in costs.

In the implementation of this project, CSRHS will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, CSRHS will ensure that all primary care clinics make ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for primary care clinics.

Starting Point/Baseline:
1 clinic location in Downtown San Antonio, 13 primary care providers, 29,494 total office visits

Source: CHRISTUS Santa Rosa Family Health Center internal records
Rationale:

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in the annual national Resident matching program (there were 31 osteopathic slots). The Texas higher Education Coordinating Board recommends a ratio of 1:1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas’ efforts to alleviate the state’s physician Shortage. Resident physicians provide low-cost care to needy populations and tend to remain in the state in which the complete their residency training.

Consistent with what is occurring at the state level, RHP 6 is in need of additional providers. By expanding its existing clinic and adding four additional primary care providers over the next five years, CHRISTUS Santa Rosa Health System (CSRHS) hopes to increase the number of primary care physicians practicing in Bexar County, thus improving primary care access to the community, while also strengthening an integrated health care system.

The core project components include:

a) **Expand primary care clinic space**: CSRHS will add an additional primary care clinic to its CHRISTUS Santa Rosa Westover Hills Campus in DY2.

b) **Expand primary care clinic hours**: CSRHS will add a total of 4 new primary care physicians by DY5. In doing so, the number of available appointment hours will be increased according.

c) **Expand primary care clinic staffing**: As a result of the additional clinic and physicians, CSRHS will increase the number of clinic staff to adequately support the additional volume.

Two major milestones were selected to ensure that this project achieves the intended results:

1) **Establish additional/expand existing/relocate primary care clinics**: The addition of a clinic and new providers in far northwest San Antonio will allow CSRHS to increase access in a currently underserved area.

2) **Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers**: CSRHS plans to hire a total of 4 new primary care providers by DY5 to staff the new clinic in far northwest San Antonio. This will provide much needed access to this underserved area.

Unique community need identification numbers the project addresses:

- **CN.2** – High prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.
**CN.3 -** Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

**How the project represents a new initiative or significantly enhances an existing delivery system:**

The CHRISTUS Santa Rosa Family Health Center, an NCQA level III medical home, is planning to expand to a new medically underserved location in San Antonio. To adequately provide the much needed access to this population, CSRHS will increase the number of primary care providers by 4 over the next four years.

**Related Category 3 Outcome Measure(s):**

- OD-9 Right Care Right Setting
- IT-9.2 ED Appropriate Utilization
  - Reduce all ED visits

**Reasons/rationale for selecting the outcome measure:**

The lack of primary care access has a direct correlation with increased utilization in the ED. The growing shortage of primary care workforce personnel in Texas is a critical problem that has contributed to increased wait times in hospitals, community clinics, and other care settings. Patients with non-emergent issues are using the ED for their primary care needs, which is a costly burden to the health care system. The primary goal of this project is to train more workforce members to serve as a primary care provider, which will help address this substantial shortage, therefore giving patients a less costly alternative to the ED.

**Relationship to other Projects:**

Expanding primary care supports/reinforces several of the Category 1 and 2 projects: Increasing the number of physicians rotating through the primary care residency program will have a direct impact on *Expanding Primary Care Capacity (1.1)*; this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; finally, the medical home concept of this training program also reinforces the *Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4)*

**Relationship to Other Performing Providers’ Projects in the RHP:**

- University Hospital
- Baptist Medical Center
- Children’s Hospital of San Antonio
- Frio Regional Hospital
- Guadalupe Regional Medical Center
- Peterson Regional Medical Center
- Medina Regional Hospital
- Val Verde Regional Medical Center
- University of Texas Health Science Center
**Plan for Learning Collaborative:**

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

**Project Valuation:**

The valuation of CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The recruitment and expansion of primary care clinics and physicians will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
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**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1**
P-1: Establish additional/expand existing/relocate primary care clinics
**Metric 1 P-1.1:** Number of additional clinics or expanded hours or space
  Goal: Add 1 additional clinic at CHRISTUS Santa Rosa Westover Hills Campus
  Data Source: Documentation of detailed expansion plans

Milestone 1 Estimated Incentive Payment: $1,990,269

**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 2**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
**Metric 1 P-5.1:** Documentation of increased number of Providers and staff and/or increase the number of primary care clinics for existing providers.
  Goal: 2
  Data Source: Physician employment agreement

Milestone 2 Estimated Incentive Payment: $2,171,277

**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 3**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
**Metric 1 P-5.1:** Documentation of increased number of Providers and staff and/or increase the number of primary care clinics for existing providers.
  Goal: 1
  Data Source: Physician employment agreement

Milestone 3 Estimated Incentive Payment: $1,088,794

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 4**
I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
**Metric 1 I-12.1:** Documentation

**Milestone 5**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
**Metric 1 P-5.1:** Documentation of increased number of Providers and staff and/or increase the number of primary care clinics for existing providers.
  Goal: 1
  Data Source: Physician employment agreement

Milestone 5 Estimated Incentive Payment: $899,439

**Milestone 6**
I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
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<th>Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 29,494 Goal: additional 4,500 visits Data Source: Athena Practice Management System</th>
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### Identifying Project and Provider Information:

**Title:** 1.9.2 Improve access to specialty care  
**Unique RHP ID #:** 112742503.1.1 – PASS 1  
**Performing Provider:** Clarity Child Guidance Center  
**Performing Provider TPI:** 112742503

### Project Summary:

**Provider Description:** Clarity Child Guidance Center is a non-profit children’s psychiatric hospital located in San Antonio, Texas, providing a continuum of services, from preventive therapy to acute care. Our 52-bed hospital, along with day treatment and outpatient therapy will help over 8,000 children. Patients primarily arrive from Bexar County, with a county seat that is the 7th largest city in the nation. However, 20% of Clarity’s patients arrive from surrounding rural counties, which often lack any psychiatric services.

**Intervention(s):** This project will provide the “right care at the right time”, in order to assess children’s psychiatric needs and provide the appropriate treatment plans. Five beds of a 20 bed expansion will be reserved as a regional psychiatric service to assess patients sooner and provide the appropriate treatment plan. Since Clarity offers a continuum of services, the appropriate treatment plan is expected to involve preventive outpatient therapy, thereby avoiding acute care in some cases. We will also free up busy emergency rooms from patients who present with psychiatric symptoms, yet psychiatric care is not immediately available.

**Need for the project:** Over 1,300 children present at local emergency rooms presenting with psychiatric symptoms, only to be “boarded” for care. We propose creating a children’s regional psychiatric service where the patient can be assessed and treatment plans implemented, bypassing ER’s where psychiatric services are often not available. We anticipate that over 300 children and adolescents per year can be assessed for services, with a continuum of care provided that can result in treatment plans such as a referral, individual, family or group therapy, medication evaluation, medication management, psychological assessments and consultations or partial hospitalization as alternatives to acute care hospitalization.

**Target population:** Children and adolescents, ages 3-17, primarily with the Medicaid population, as we are a disproportionate share hospital and one of only a few resources providing serious mental health care in our region. Expanding our continuum of services, including preventive behavioral health services, to more Medicaid children has a substantial community impact.

**Category 1 or 2 expected patient benefits:**
- Divert patients from presenting at ERs where care is not readily accessible
- Assess patients (>300) for best treatment courses related to mental health in DY4 and DY5
- Provide the appropriate level of care to patients ages 3-17
- Thereby, decreasing unnecessary hospital admissions for acute care, while increasing preventive treatment options such as outpatient therapy and increasing satisfaction 2%

**Category 3 outcomes:**
Our goal is to reduce the behavioral health acute admission rate for children and adolescents, with the percentage improvement to be determined after creating a baseline in DY3.

### Project Description:

Clarity Child Guidance Center proposes to provide regional psychiatric services to children ages 3-17 in a setting where a continuum of care is available, to effectively divert patients from local
ER settings into the appropriate care level.

A report completed in 2010 by Methodist Healthcare Ministries researched children's psychiatric beds in our region and revealed a 21 bed deficit, which has grown to 65 beds over the past two years. The Texas Department of State Health Services concurs with those findings, noting that in the last 17 years, psychiatric beds have shrunk by more than 30%, while demand continues to soar. Compounding the problem is the increased incidence of mental health crises. Root causes of mental health illness can often be traced to abuse and neglect of children in our community, increased obesity (which leads to depression and other mental illnesses), increased single parent homes and other factors which all lead to substantial increases in mental health needs. As a result of the increased need in children's mental health care and lack of access, 1,300 children annually present to ERs with a psychiatric condition. However, most regional hospitals do not provide psychiatric services. These hospitals have coined the term "boarding," keeping a patient in the ER until a bed is made available at another facility that does provide care.

As a solution, Clarity Child Guidance Center provides a continuum of mental health services for children ages 3-17, including acute inpatient hospitalization. We are uniquely positioned to expand capacity for the shortage of inpatient care beds for children, by creating a regional children’s psychiatric emergency service. This regional emergency service for children's psychiatric needs will help to divert the 1,300 children being boarded at ERs to a facility where appropriate mental health care can be provided. This also frees beds in ERs for patients who can be treated at local hospitals. Busy ER's turn a bed over about every two hours, meaning that creating a regional access point for children's psychiatric emergencies could open thousands of traditional ER beds by caring for children more appropriately in Clarity CGC's clinical settings.

It is Clarity CGC’s history and focus on children’s mental health and a continuum of care, including outpatient therapy and day treatment that will prevent many children from being hospitalized. Our expected outcome is a reduction in Pediatric ER visits to hospitals that lack care while offering a treatment plan that includes options such as outpatient therapy, day treatment, and if medically necessary, acute emergency services.

**Goals and Relationship to Regional Goals:**
Our goal is reduce ER admissions in settings where care is not readily available, while providing a continuum of mental health services to children ages 3-17. By providing the right care in the right setting, we can reduce admissions and increase preventive care treatment.

**Project Goals:**
- Divert patients from presenting at ERs where care is not readily accessible
- Assess patients for best treatment courses related to mental health
- Provide the appropriate level of care to patients ages 3-17
- Thereby, decreasing unnecessary hospital admissions for acute care, while increasing preventive treatment options such as outpatient therapy

This project meets the following regional goals:
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective way; and
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
Challenges:
The primary challenge for this project will be the coordination and communication with regional hospitals that don’t offer psychiatric care for children ages 3-17 to ensure their knowledge and processes for referring patients to our regional services. With effective communication and coordination, the project will be successful.

5-Year Expected Outcome for Provider and Patients:
Clarity Child Guidance Center expects to see improvements in behavioral healthcare outcomes for patients assessed and treated. Patients will be surveyed on satisfaction and improvements initiated as a result of all metrics.

Starting Point/Baseline:
The following data/information about our organization would help establish a baseline in DY2:
- Nearly 7,000 children served through outpatient therapy services resulting in 21,000 outpatient visits
- The largest concentration of trained professionals already on staff, with capacity to grow to increase service availability through the creation of a regional children’s psychiatric emergency service

Rationale:
Project 1.9.2 seeks to increase the capacity to provide specialty care services and the availability of targeted specialty providers to improve access to specialty care. As one of only four providers for children in our region suffering from serious mental illness, and the only nonprofit providing services to children as young as three, we believe we are uniquely qualified to expand and enhance service availability. The project option of 1.9.2 is the best alignment to our project goal, as we will be increasing capacity to behavioral health services, while increasing the number of providers.

Project Components:
With the design, development and deployment of the Regional Children’s Psychiatric Services project, we propose to meet all required project components.

a) Increase service availability with extended hours. Through collaboration and a referral network, we will increase service availability by creating a regional psychiatric emergency service for children ages 3-17. The psychiatric emergency service shall be available 24/7 to the community.
b) Increase number of specialty clinic locations. A 65-bed deficit of children’s psychiatric beds exits in our community. This project seeks to increase the number of beds to 20, with five beds reserved for a regional psychiatric service. This effort inherently increases capability and capacity, which is the intent of item b).c) Implement transparent, standardized referrals across the system. Clarity Child Guidance Center is part of the health information exchange effort to create a pathway for transparent, standardized referrals. Even independent of this effort, we maintain a large referral base (both referring in or out of our system). We intend to expand the referral base as a result of this project.d) Conduct quality improvement for project using methods such as rapid cycle. A project management team will deploy this initiative, creating the opportunity for quality improvements. Further, standardized processes within our hospital system allow for rapid cycle improvements, through suggestions, policy updates, and various
councils and committees who evaluate metrics and processes for improvement opportunities.

**Unique community need identification numbers the project addresses:** Our project aligns with the Region’s needs as outlined in the Community Needs Assessment, specifically to the following identification areas:

- **CN.1** Texas ranks last in the nation on health care quality. *In particular, Texas ranks last on nearly all mental health indicators.* An investment in a behavioral health project such as Clarity CGC’s creates the foundation to change this trend.

- **CN.2** Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages. *We care for the uninsured and under-insured daily.* We are one of only four providers in the region that offer serious mental health treatment for children ages 3-17, and we are the only provider on the 1115 waiver list that would provide services specifically as young as three.

- **CN.4** There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization. *Clarity CGC currently offers the largest concentration of child and adolescent professionals in the region, through our partnership with Southwest Psychiatric Physicians and our affiliation with The University of Texas Health Science Center’s Department of Psychiatry.* We are uniquely positioned to increase the number of providers, services, and integrate with physical health. Part of our project planning is to expand our affiliation with UTHSC to the Pediatrics Department.

Our project represents both a new and expanded initiative. First, it’s new in its thought process of creating a regional psychiatric emergency service to prevent “boarding” of children in hospitals who lack appropriate providers and care and who merely transfer their patients to our facility and precious few others, on average 12 hours after admission. Second, it’s an expanded initiative in that Clarity CGC offers a continuum of services based on decades of service. We offer outpatient therapy, day treatment and acute inpatient hospitalization (for a fraction of the cost of standard pediatric ER settings). Third, through our established affiliation with The University of Texas Health Science Center’s Department of Psychiatry, we are positioned to form a similar affiliation with Pediatrics, creating a system of integrated care.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

This project reflects a new initiative in that it seeks to regionalize psychiatric emergency services where care is available, versus the many existing ER’s where children are “boarded” for care. As for data to support the need, one in five children will be diagnosed with a mental, emotional or behavioral disorder (affecting over 80,000 children in Bexar County alone).

Clarity CGC is a disproportionate share hospital and will continue to serve Medicaid/CHIP children presenting with psychiatric symptoms in order to assess and provide the best treatment plan.

Texas ranks last in per capita spending on mental health care for children amongst all states. Improvements in mental health delivery and outcomes are critical for our overall community’s
health.

**Related Category 3 Outcome Measure(s):**

We have selected a measure within OD-2, “Potentially Preventable Admissions” and the related standalone outcome measure of 3-IT 2-4. This measure’s goal is to reduce Emergency Department visits for one of several optional target conditions, one of which is behavioral health/substance abuse. However, because this measure is available only for patients 18 and older, we were advised by HHSC to utilize the custom/optional measure of 2.13 to address that our outcomes would be related to youth, ages 3-17. Our project is of benefit to all performing providers in the region, as children are presenting in local Emergency Rooms without access to “right care, right setting” and displacing beds for treatment plans that can be addressed effectively by the local hospitals. Further, treating children when they are children prevents a host of unwelcome outcomes, including but not limited to suicide, incarceration, dropout, alcohol and drug abuse and many other societal ills.

Our Category 1 Project, to improve access to specialty care, directly links to potentially preventable admissions, a key outcome of 2.13. Improving the health of low-income populations will lead to long-term sustainable outcomes while decreasing societal burden.

**Relationship to other Projects:**

Improving behavioral care outcomes is a key tenet of the 1115 Waiver and also prominently noted in the Community Needs Assessment for our Region. The Center for Healthcare Services (CHCS) has multiple companion projects in the behavioral health areas of Category 1 and 2. Our project (112742503.1.1) will have several integrated links with the multitude of CHCS projects. Specifically, our project ties into Category 4 measures such as Potentially preventable admissions (RD-1.3); 30-day readmissions (RD-2.3); Patient Centered healthcare (RD-4.1), including patient satisfaction and medication management; and finally, Emergency Department (RD-5). We believe we will be exempt from many of the measures in RD-3, potentially preventable complications (PPCs), as our hospital is specialized in behavioral health treatment.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The Center for Healthcare Services has multiple companion projects in the behavioral health areas of Category 1 and 2. Following completion of the RHP Plan, our anchor, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure. University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaborative to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.
**Plan for Learning Collaborative:**

In addition to the information shared directly above, we are members of the Bexar County Health Collaborative. Additionally, we are a teaching hospital, affiliated with the UTHSC, where outcomes will be openly shared as part of the learning process. Staff is also members of the Community Resource Coordination Group (CRCG) for both Bexar County and the surrounding counties. We are also members of the MDRC, a group of medical directors that meets quarterly that was formed by Judges at the Probate Court. Ideas will be shared, tested, and solutions provided as part of our membership process.

**Project Valuation:**

The total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.
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<tr>
<th>Milestone 1</th>
<th>Milestone 3</th>
<th>Milestone 4</th>
<th>Milestone 5</th>
<th>Milestone 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1: Conduct specialty care gap assessment</td>
<td>P-4: Expand ambulatory care medical specialties referral management</td>
<td>P-11: Launch/expand a specialty care clinic</td>
<td>P-13: Complete planning and installation of new specialty systems (e.g., imaging systems)</td>
<td>Milestone 8 P-21: Participate in face to face learning at least twice a year with other providers and the RHP to promote collaborative learning.</td>
</tr>
<tr>
<td>Metric 1 (P-1.1) Data Source: Documentation of gap assessment.</td>
<td>Metric 3 (P-4.2) Data Source: Policy development for and staff training on referral system</td>
<td>Metric 4 (P-11.1) Data Source: Establish/expand specialty care clinic as per evidence of opening</td>
<td>Metric 5 (P-13.1) Data Source: Documentation of planning and installation of new specialty systems.</td>
<td>Metric 8 (P-21.1) Data Source: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Signed attendance logs as evidence.</td>
</tr>
<tr>
<td>Goal: Documentation of gap assessment</td>
<td>Goal: Policy developed; Staff needing training identified; completion of training with documentation; 100%</td>
<td>Goal: ≥300 patients assessed for services</td>
<td>Goal: Increase number of specialty care visits.</td>
<td>Goal: Completion of a minimum of two learning events per year.</td>
</tr>
</tbody>
</table>

**Milestone 1 Estimated Incentive Payment:** $352,467

**Milestone 2**

P-2: Train specialty care providers and staff on processes, etc.

Metric 2 (P-2.1) Data Source: Training of staff; documentation of materials; 100%

Goal: Staff needing training identified; completion of training identified; documentation of materials; 100%

**Milestone 3 Estimated Incentive Payment:** $769,013

**Milestone 4 Estimated Incentive Payment:** $192,820

**Milestone 5**

P-13: Complete planning and installation of new specialty systems (e.g., imaging systems)

Metric 5 (P-13.1) Data Source: Documentation of planning and installation of new specialty systems. 

**Milestone 8 Estimated Incentive Payment:** $212,381
| Milestone 2 Estimated Incentive Payment: $352,466 | Installation of new systems  
Goal: Planning and install |
|---|---|
| Milestone 5 Estimated Incentive Payment: $192,820 | Data derived from electronic medical records.  
Goal: 5% increase over existing baseline of children/adolescents presenting for an assessment for services who then receive a service |
| **Milestone 6**  
P-14: Expand targeted specialty care (TSC) training  
Metric 6 (P-14.2) Data Source: Hire additional precepting TSC faculty members; data derived from HR hiring records  
Goal: 100% of key positions hired  
Process Milestone 6 Estimated Incentive Payment: $192,820 | **Milestone 9 Estimated Incentive Payment: $212,381** |
| **Milestone 7**  
I-23: Increase specialty care clinic volume of visits and evidence of access for patients seeking services  
Metric 7 (I-23.2) Data Source: Documentation of increased number of visits. Data derived | **Milestone 10**  
P-11: Launch/expand a specialty care clinic  
Metric 10 (P-11.1) Data Source: Establish/expand specialty care clinic as per evidence of increased referral partnerships in DYS, resulting in patients assessed  
Goal: ≥300 patients assessed for services  
Milestone 9 Estimated Incentive Payment: $212,381 |
from electronic medical records.

Goal: 5% increase over existing baseline of children/adolescents presenting for an assessment

Milestone 7 Estimated Incentive Payment: $192,820

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $704,933</th>
<th>Year 3 Estimated Milestone Bundle Amount: $769,013</th>
<th>Year 4 Estimated Milestone Bundle Amount: $771,280</th>
<th>Year 5 Estimated Milestone Bundle Amount: $637,143</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,882,369**
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>Project Option 1.9.1 EXPAND HIGH IMPACT SPECIALTY CARE CAPACITY IN MOST IMPACTED SPECIALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>135151206.1.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Connally Memorial Medical Center</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>135151206</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider Description:** Connally Memorial Medical Center (CMMC) is a 44-bed hospital in Floresville, TX. CMMC is the sole community hospital serving Wilson County with a population of 43,000.

**Intervention(s):** CMMC will establish hospital owned and operated specialty clinics for targeted specialty care services based on community need.

**Need for the project:** Establishing specialty care clinics will allow CMMC to expand specialty services for most impacted specialties and improve access for targeted populations. A project to expand high impact specialty care is needed in Wilson County and the surrounding areas. The leading causes of death in Wilson county are related to cardiovascular conditions (30% of all deaths) and heart diseases (24%). Based on the GMNEC Model for physician to population ratios, Wilson County has a shortage of 34 physicians (representing all specialties). Additionally, Wilson County has been designated as a Health Provider Shortage Area as well as a Medically Underserved Area by the U.S. Department of Health and Human Services.

**Target population:** Our target population would be all of Wilson County. Currently in Wilson County 10% of the population lives below the federal poverty level. Additionally, 23% of our patients are either Medicaid eligible or indigent/self pay, so we expect they will benefit from this service.

**Category 1 or 2 expected patient benefits:** The project seeks to provide 17,402 specialty clinic encounters/consults from DY2 – DY5. Hospital does not currently operate any specialty clinics, therefore all specialty encounters/consults will be new services provided to community, thus increasing access to care.

**Category 3 outcomes:** IT-1.6 Cholesterol Management for patients with cardiovascular conditions
Our goal is to reduce the total blood cholesterol level for patients with known heart disease. Goal is TBD

### Project Description:

Connally Memorial Medical Center proposes to establish hospital owned and operated specialty clinics for targeted specialty care services based on community need. Specialty clinics will provide care for unassigned patients and will coordinate care with primary care clinics, and hospital emergency department to expand access to specialty services. Connally Memorial Medical Center serves a population of over 40,000 residents.

### Goal and Relationship to regional Goals:

The overarching goal of this project is to improve clinical health outcomes for residents of...
Wilson County. We will work toward achieving that goal by recruiting specialty providers to Wilson County, establishing specialty care clinics and implementing an electronic health record within these clinics to better coordinate care and referrals from primary care physicians.

**Project Goals**
1. Increase the number of specialty providers
2. Increase the number of patients seen in specialty clinics

This project meets the following regional goals.
1. Improves outcomes while containing cost growth.
2. Develops and maintains a coordinated care delivery system.
3. Assures patients receive high-quality and patient-centered care in the most cost effective ways.

**Challenges:**
The primary challenge for this project will be to recruit specialty providers to our community. Small and rural communities, such as Wilson County, have historically had a difficult time attracting and retaining physicians.

**5 Year expected outcome for Provider and Patients:**
Connally Memorial Medical Center expects to see improvements in the number of specialist providers available to treat patients in Wilson County. Additionally, the provider expects to see improvements in the health outcomes for chronic diseases and health disparities outlined in the community needs assessment.

**Starting Point/Baseline:**
No current baseline exists as the hospital does not currently own and operate any specialty clinics. Therefore, the baseline number for encounters as well as the participating providers begins at 0 in DY 2.

**Rationale:**
CMMC has chosen the project option of *Expanding high impact specialty care capacity in most impacted specialties*. Establishing specialty care clinics will allow CMMC to expand specialty services for most impacted specialties and improve access for targeted populations. Additionally, specialty care clinics allow for enhanced care coordination for those patients requiring intensive specialty services. A project to expand high impact specialty care is needed in Wilson County and the surrounding areas. The leading causes of death in Wilson county are related to cardiovascular conditions (30% of all deaths) and heart diseases (24%). Based on the GMNEC Model for physician to population ratios, Wilson County has a shortage of 34 physicians (representing all specialties) Additionally, Wilson County has been designated as a Health Provider Shortage Area as well as a Medically Underserved Area by the U.S. Department of Health and Human Services. In addition to already being underserved, the Wilson County population is expected to increase by 24% by 2015.

**Project Components**
   a) Identify high impact/most impacted specialty services and gaps in care coordination – CMMC will conduct a formal specialty needs assessment to determine most impacted specialty services and gaps in care.
b) Increase the number of residents/trainees. CMMC will not initially address this component due to the fact that provider does not offer a residency training program.

c) Design workforce enhancement initiatives to support access to specialty providers. CMMC will recruit additional specialty providers to support goal of providing additional services in underserved markets.

d) Conduct quality improvement for project using methods such as rapid cycle improvement – CMMC will expand and implement hospital EMR to specialty clinics. We will create a registry of patients seen in CMMC inpatient setting and emergency department to help facilitate clinical follow up to outpatient setting. Reports will be run monthly and shared with specialty clinic staff at monthly meetings. Meetings will be held monthly to discuss any issues associated with communication between hospital and clinic providers as well as patient transfers.

Community need Identification number:
- CN.2 (A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer and diabetes.)
- CN.3 (Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and healthcare provider shortages.)

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative.
Currently there are no hospital based clinics in Wilson County. The Wilson County medical community is a system of independent medical providers including private physician groups, clinics and Connally Memorial Medical Center. Our project will improve access for targeted patients while helping CMMC reach capacity for treating patients with specialty needs. More specifically, we will increase the number of specialty clinic locations and service availability. This will in turn allow patients to have greater access to hospital resources including quality improvement, case management and social services.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

IT-1.6 Cholesterol Management for patients with cardiovascular conditions

Reasons/rationale for selecting the outcome measures:
Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build up of plaque. Hemorrhagin or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stoke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close
monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Relationship to other Projects:
This project’s focus on treating patients with cardiovascular conditions and preventing conditions such as heart attack and stroke supports our Category 1 project in our RHP: 135151206.1.1- Expand Specialty Care Capacity. Related Category 4 measures include potentially preventable admissions in RD-1 and Potentially Preventable Complications in RD-3.

Relationship to Other Performing Providers’ Projects in the RHP:
n/a

Plan for Learning Collaborative:
n/a

Project Valuation:
Wilson County is underserved by many specialty care providers. The possible expansion of Medicaid services in 2014, with the inherent pent-up demand for services, will exacerbate this shortage. Multiple sources of information document a specialty care shortage in many specialties. Many health specialty services have wait times of greater than 2 weeks for the third available appointment, our primary care network is growing rapidly, the northern county area of Wilson and Karnes Counties are rapidly growing in population. Expanding specialty services will also expand preventive services for patients in this area. Our electronic medical record will allow seamless referrals and communication between our primary care and specialist providers. Additional specialty access will improve the quality of care and health care outcomes in the community.
<table>
<thead>
<tr>
<th>135151206.1.1 PASS 1</th>
<th>1.9.1</th>
<th>A, C, D</th>
<th>EXPAND HIGH IMPACT SPECIALTY CARE CAPACITY IN MOST IMPACTED SPECIALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connally Memorial Medical Center</td>
<td>TPI - 135151206</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>135151206.3.1</td>
<td>3.1T-1.6</td>
<td>Cholesterol management for patients with cardiovascular conditions</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Conduct specialty gap assessment based on community need</td>
<td><strong>Milestone 4</strong> [P-11]: Expand specialty care clinic</td>
<td><strong>Milestone 6</strong> [P-7]: Complete a planning process/submit a plan to implement electronic referral technology</td>
<td><strong>Milestone 9</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td>Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period</td>
<td>Metric 1 [P-11.1]: Number of patients served by clinic</td>
<td>Metric 1 [P-7.2]: Development of an implementation plan for e-referral.</td>
<td>Metric 1 [I-23.1]: Documentation of increased number of visits</td>
</tr>
<tr>
<td>Goal: Produce a comprehensive report that identifies most needed specialties.</td>
<td>Goal: 20% Increase in number of patient encounters in DY 2</td>
<td>Baseline: No plan exists currently.</td>
<td>Goal: increase in number of patient encounters by 10% from Year 4</td>
</tr>
<tr>
<td>Baseline: No program or assessment exists currently</td>
<td>Data Source: Documentation of new/expanded clinic</td>
<td>Data Source: Referral plan</td>
<td>Data Source: EMR</td>
</tr>
<tr>
<td>Data Source: Needs assessment</td>
<td>Milestone 4 Estimated Incentive Payment: $307,305.50</td>
<td>Milestone 6 Estimated Incentive Payment: $205,466</td>
<td>Milestone 9 Estimated Incentive Payment: $254,599</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $187,791.67</td>
<td><strong>Milestone 5</strong> [I-22]: Increase the number of specialist providers for high impact specialties.</td>
<td><strong>Milestone 7</strong> [P-11]: Expand specialty care clinic</td>
<td><strong>Milestone 10</strong> [I-22]: Increase the number of specialist providers, clinic hours and procedure hours</td>
</tr>
<tr>
<td>Metric 1 [P-11.1]: Number of patients served by clinic</td>
<td>Metric 1 [P-11.1]: Number of patients served by clinic</td>
<td>Metric 1 [P-11.1]: Number of patients served by clinic</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
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</tr>
</tbody>
</table>
| [P-11]: Launch a specialty care clinic  
**Metric 1 [P-11.1]:** Establish specialty care clinics  
Goal: 3,500 patient encounters  
Baseline: 0 patients; No program exists currently  
Data Source: Documentation of new specialty care clinic  
Milestone 2 Estimated Incentive Payment: $187,791.67 | [I-22]: Increase the number of specialist providers, clinic hours and procedure hours available for high impact medical specialties  
**Metric 1 [I-22.1]:** Increase number of specialist providers, clinic hours and procedure hours in targeted specialties  
Goal: Based on community  
Baseline: 3,500 patient encounters  
Goal: 2 specialist providers  
Data Source: Documentation demonstrating employed or contracted specialists  
Milestone 5 Estimated Incentive Payment: $307,305.50 | clinic  
Baseline: 0  
Goal: 10% Increase in number of patient encounters in DY 3  
Data Source: Documentation of new/expanded clinic  
Milestone 7 Estimated Incentive Payment: $205,466 | **Milestone 8**  
[I-22]: Increase the number of specialist providers, clinic hours and procedure hours available for high impact medical specialties  
**Metric 1 [I-22.1]:** Increase number of specialist providers, clinic hours and procedure hours in targeted specialties  
Goal: Based on community needs assessment, increase in number of providers and/or procedures hours available  
Baseline: 0  
Data Source: Documentation of employed or contracted specialists  
Milestone 10 Estimated Incentive Payment: $254,599 |

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**Milestone 9**  
[I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours available for high impact medical specialties  
Goal: Based on community needs assessment, increase in number of providers and/or procedures hours available  
Baseline: 0  
Data Source: Documentation of employed or contracted specialists  
Milestone 10 Estimated Incentive Payment: $254,599

---
<table>
<thead>
<tr>
<th>Needs Assessment, Increase in Number of Providers and/or Procedures Hours Available</th>
<th>Data Source: Documentation of Employed or Contracted Specialists</th>
<th>Milestone 8 Estimated Incentive Payment: $205,466</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 0</td>
<td>Milestone 3 Estimated Incentive Payment: $187,791.67</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $563,375</td>
<td>Year 3 Estimated Milestone Bundle Amount: $614,611</td>
<td>Year 4 Estimated Milestone Bundle Amount: $616,398</td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $509,198</td>
<td><strong>Total Estimated Incentive Payments for 4-Year Period: $2,303,582</strong></td>
<td></td>
</tr>
</tbody>
</table>
Identifying Project and Provider Information:

Title: 1.1.1 ESTABLISH MORE PRIMARY CARE CLINICS
Unique RHP ID#: 135151206.1.2 – PASS 2
Performing Provider: Connally Memorial Medical Center
Performing Provider TPI: 135151206

Project Summary:

Provider Description: Connally Memorial Medical Center (CMMC) is a 44-bed hospital in Floresville, TX. CMMC is the sole community hospital serving Wilson County with a population of 43,000

Intervention(s): Connally Memorial Medical Center proposes to establish additional hospital owned and operated primary care clinics.

Need for the project: Additional primary care clinics will provide care for unassigned patients and will coordinate care with other medical providers, including hospital emergency department and specialty physicians. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcome, patient satisfaction, and appropriate utilization and reduced cost of services.

Target population: Our target population would be all of Wilson County. Currently in Wilson County 10% of the population lives below the federal poverty level. Additionally, 23% of our patients are either Medicaid eligible or indigent/self pay, so we expect they will benefit from this service.

Category 1 or 2 expected patient benefits: The project seeks to provide 12,000 primary care clinic encounters/consults from DY2 – DY5

Category 3 outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores

Our goal is to increase the level of patient satisfaction for patients in primary care clinics. Goal is TBD.

Project Description:

Connally Memorial Medical Center proposes to establish additional hospital owned and operated primary care clinics. Additional primary care clinics will provide care for unassigned patients and will coordinate care with other medical providers, including hospital emergency department and specialty physicians.

Connally Memorial Medical Center serves a population of over 40,000 residents.

Goal and Relationship to regional Goals:

The overarching goal of this project is to expand primary care to better accommodate the needs of the Wilson County patient population as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

We will work toward achieving that goal by recruiting more primary care providers to Wilson
County, establishing more primary care clinics and implementing an electronic health record within these clinics to better coordinate care and referrals from other providers.

**Project Goals**

3. Increase the number of primary care providers
4. Increase the number of patients seen in primary care clinics

**This project meets the following regional goals.**

4. Improves outcomes while containing cost growth.
5. Develops and maintains a coordinated care delivery system.
6. Assures patients receive high-quality and patient-centered care in the most cost effective ways.

**Challenges:**
The primary challenge for this project will be to recruit primary care providers to our community. Small and rural communities, such as Wilson County, have historically had a difficult time attracting and retaining physicians.

**5 Year expected outcome for Provider and Patients:**
Connally Memorial Medical Center expects to see improvements in the number of primary care providers available to treat patients in Wilson County. Additionally, the provider expects to see improvements in the health outcomes for chronic diseases and health disparities outlined in the community needs assessment.

**Starting Point/Baseline:**
No current baseline exists as the hospital does not currently own and operate any specialty clinics. Therefore, the baseline number for encounters as well as the participating providers begins at 0 in DY 2.

**Rationale:**
CMMC has chosen the project option to establish more primary care clinics. In our current system patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcome, patient satisfaction, and appropriate utilization and reduced cost of services.

Based on the GMNEC Model for physician to population ratios, Wilson County has a shortage of 34 physicians (representing all specialties) Additionally, Wilson County has been designated as a Health Provider Shortage Area as well as a Medically Underserved Area by the U.S. Department of Health and Human Services. In addition to already being underserved, the Wilson County population is expected to increase by 24% by 2015.
Community need Identification number:
- CN.1 Texas ranks last in the nation on healthcare quality. RHP 6 is challenged to deliver improved quality and patient satisfaction
- CN.2 A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer and diabetes.)
- CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and healthcare provider shortages.)

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently there are no hospital based clinics in Wilson County. The Wilson County medical community is a system of independent medical providers including private physician groups, clinics and Connally Memorial Medical Center. Our project will improve access for targeted patients while helping CMMC reach capacity for treating patients with primary care needs. More specifically, we will increase the number of primary care clinic locations and service availability. This will in turn allow patients to have greater access to hospital resources including quality improvement, case management and social services.

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-6 Patient Satisfaction</td>
</tr>
<tr>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
</tbody>
</table>

Reasons/rationale for selecting the outcome measures:
The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

<table>
<thead>
<tr>
<th>Relationship to other Projects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project’s focus on patient satisfaction and HCAHPS initiatives supports our Category 1 project in our RHP: 135151206.1.2- Establish more primary care clinics. Over time, implemented projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care.</td>
</tr>
<tr>
<td>Related Category 4 measures include potentially preventable admissions in RD-1 and Potentially Preventable Complications in RD-3.</td>
</tr>
<tr>
<td>Relationship to Other Performing Providers’ Projects in the RHP:</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Plan for Learning Collaborative:</td>
</tr>
<tr>
<td>Project Valuation:</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): 135151206.3.2</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
</tr>
<tr>
<td><strong>P-1</strong>: Establish additional/expand existing/relocate primary care clinics</td>
</tr>
<tr>
<td><strong>Metric 1 [P-1.1]</strong>: Number of additional clinics or expanded hours or space</td>
</tr>
<tr>
<td>Goal: Establish 1 new primary care clinic Baseline: 0 Data Source: New primary care schedule; expansion plans</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $75,015</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
</tr>
<tr>
<td><strong>I-15</strong>: Increase access to primary care capacity. <strong>Metric 1 [I-15.2]</strong>: Increase number of primary care visits</td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $54,309</td>
</tr>
<tr>
<td>Milestone 2</td>
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<tr>
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</tr>
<tr>
<td>Goal: 2,600 patient encounters for patients seeking services.</td>
</tr>
<tr>
<td>Baseline: 0 patients; No program exists currently</td>
</tr>
<tr>
<td>Data Source: EMR</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 4</th>
<th>Estimated Incentive Payment: $54,309</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: 100 new unique patients</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 5</th>
<th>Estimated Incentive Payment: $54,309</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-15: Increase access to primary care capacity.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-15.2]: Increase number of primary care visits</td>
<td></td>
</tr>
<tr>
<td>Goal: 2,860 patient encounters</td>
<td></td>
</tr>
<tr>
<td>Baseline: 0 patients; No program exists currently</td>
<td></td>
</tr>
<tr>
<td>Data Source: EMR</td>
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<table>
<thead>
<tr>
<th>Milestone 7</th>
<th>Estimated Incentive Payment: $53,663</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-15: Increase access to primary care capacity.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-15.2]: Increase number of primary care visits</td>
<td></td>
</tr>
<tr>
<td>Goal: 3,146 patient encounters</td>
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<tr>
<td>I-15: Increase access to primary care capacity.</td>
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<td>Metric 1 [I-15.2]: Increase number of primary care visits</td>
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<tr>
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<td>Metric 1 [I-15.2]: Increase number of primary care visits</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $600,080**
Identifying Project and Provider Information:
Title: 1.9.1 Expand high impact specialty care capacity in most impacted medical specialties: Improving Rural Access to Specialty Care
Unique RHP ID#: 112690603.1.1 – PASS 1
Performing Provider: Dimmit Regional Hospital (previously Dimmit County Memorial Hospital)
TPI: 217884001

Project Summary:
Provider Description: Dimmit Regional Hospital (previously Dimmit County Memorial Hospital) is a 45-bed hospital located in Carrizo Springs, TX. The hospital serves Dimmit County, population approximately 10,000, across 1,329 square miles.
Intervention(s): The project will expand the range of specialty care services and providers available to our rural population. Increasing access will decrease transfers to specialist providers in San Antonio.
Need for the project: Currently the hospital has a very high rate of patient transfers for its size (100/month). This rate is expected to increase as the population continues to grow in response to nearby oil and natural gas operations. A shortage of local specialty providers is the main cause for these transfers with the most notable gap being the lack of a general surgeon. Currently these transferred patients travel 100+ miles to San Antonio to for specialty care.
Target population: The target population is our patients in need of specialty care. Our current Medicaid inpatient utilization rate is 67% and our low income utilization rate is 70%. Approximately 32% of our population is uninsured.
Category 1 or 2 expected patient benefits: Cut the patient transfer rate in half (to 50/month) through specialty care capacity expansion and quality improvements.
Currently we are recruiting a general surgeon, an internal medicine physician, and a general practitioner. Recruitment into these and other specialties will likely be completed by the end of DY 3. Based on these specialties with the need and potential for recruitment, we anticipate 2,000 specialty visits and/or procedures by the end of DY 4 for these new specialties. In DY 5 we have set a goal to increase this number to 2,500 specialty visits and/or procedures for these new specialties.
For all specialist providers we expect an average of 2 visits per patient per year.
Category 3 outcomes: IT-6.1 Our goal is to improve patient satisfaction scores over DY 3 baseline, specifically in regards to the patient’s rating of doctor access to a specialist. Actual percentage improvement goals TBD in DY 3.

Project Description:
Dimmit Regional Hospital proposes to expand its specialty care capacity to meet the needs of its growing rural population.
Dimmit Regional Hospital (DRH) is seeking to improve access to specialty care for its rural community. DRH is a 45 bed non-profit public hospital owned by Dimmit Regional Hospital District. It is located approximately 100 miles southwest of San Antonio. Currently, due to the extremely limited specialty services offered by DRH, the patient transfer rate is very high (avg. 100/month). These transferred patients are required to drive 1.5 – 2 hours one way for specialty care in San Antonio. This places an undue hardship on a low income rural population that is 86% Hispanic. These transfers are anticipated to increase dramatically as the rural population is experiencing a large growth in population, due to the nearby Eagle Ford shale natural gas and oil operations. DRH seeks to eliminate this hardship on local families by expanding high impact specialty care capacity in the most impacted medical specialties, improving local access to
specialty care.

We will reduce patient transfers and reach the associated Cat. 3 outcome improvement target (improve patient satisfaction scores – patient’s rating of doctor access to a specialist) through implementing the project in 4 steps from DY 2 – 5. First, we will conduct a specialty care gap analysis to identify the medical specialties with the highest potential for positive impact on the health of our population, i.e. our greatest community need. This will also establish a baseline for the future steps of our project.

Next, we will train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Then we will increase the number of specialist providers, clinic hours and/or procedure hours in targeted specialties. During the two years following this expansion in capacity we will attend semi-annual learning collaborative meetings hosted by the RHP 6 anchor facility. At these meetings we will share lessons learned and commit to implementing at least one “raise the floor” improvement initiative each year. We will then assess the impact of these specialty care improvement initiatives through ensuring that specialty care patients receive satisfaction surveys. We will put forward ideas and initiatives aimed at increasing the response rate of these surveys. These specialty care patient satisfaction surveys will also allow us to collect accurate data for achievement of our Cat. 3 outcome improvement target.

Goals and Relationship to Regional Goals:
Project Goals:
- Increase access to specialty care in the local rural community, currently a HPSA
- Improve patient rating of doctor’s access to a specialist (see Cat. 3 improvement target)
- Reduce the patient financial, health and access costs associated with a high patient transfer rate by cutting this rate in half.
- Ensure staff are well trained in medical specialty referral guidelines, processes and technology
- Implement “best practices” from semi-annual RHP 6 Anchor learning collaborative attendance, improving the quality of specialty care provided.

The project meets the following regional goals:
- Work together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered care, in the most effective ways.
  - Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
  - Further develop and maintain a coordinated care delivery system.
  - Improve outcomes while containing cost growth.

Improving rural access to specialty care in our community will significantly decrease the number of patients that are transferred more than 1.5 hours away to San Antonio for care. The alleviation of this financial hardship for patients within our low-income rural community will better serve the residents of our region. Better training of staff and redesigning clinics for improved cycle time will improve outcomes while containing cost growth.

Challenges:
In the past, a significant challenge to supporting greater specialist capacity has been low patient volumes. However, with the recent natural gas/oil boom at the Eagle Ford Shale operation, the Carrizo Springs population is growing rapidly. This growth in population is expected to continue for many years. This presents an opportunity to attract specialists into our community to support
the health needs of our growing population.

5-Year Expected Outcome for Provider and Patients:
The 5-year expected or desired outcome is to cut the average rate of transfers in half (to 50/month). This project is related to regional goals because it will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region. It will reduce the cost to the patient, the hospital and the payer. This project will achieve this through conducting quality improvement projects using methods such as rapid cycle improvement and continual project evaluation.

Starting Point/Baseline:
*Improving Rural Access to Specialty Care* does not resemble any current or previous project we have ever implemented. Each component of the project is unique. Therefore, no baseline has been established at this time. Baselines for each milestone will be established according to the time period outlined below:

**Milestone 1 [P-1]:** Current specialty services: podiatry, pediatric dentistry, ENT and cardiology. Most notable gap is lack of a general surgeon. Timeline: baseline will be established upon completion of the specialty care gap assessment in DY 2.

**Milestone 2 [P-2]:** 0, a training program of this kind has never been implemented prior to this project. Timeline: DY 2

**Milestone 3 [P-2]:** 50% of staff and providers trained in referral guidelines, process and technology. Timeline: baseline is derived from Milestone 2 goal achievement in DY 2.

**Milestone 4 [I-22]:** Currently 4 specialist providers. Timeline: DY 2, Baseline may change if any DY 2 provider changes occur.

**Milestone 5 [P-21]:** 0, attendance at RHP 6 anchor learning collaboratives or implementation of “raise the floor” improvement initiatives has never occurred previously.

**Milestone 6 [I-23]:** TBD in DY 3 after accomplishment of I-22

**Milestone 7 [I-27]:** 0, patient satisfaction surveys have not been sent to specialty clinic patients prior to the implementation of this project.

**Milestone 8 [P-21]:** 2 meetings attended in DY 4 with at least 1 “raise the floor” improvement initiative implemented.

**Milestone 9 [I-23]:** TBD in DY 3 after accomplishment of I-22

**Milestone 10 [I-27]:** 60% received surveys in DY 4 (based on Milestone 7 goal achievement in DY 4),

Rationale:
The primary reason this project option was selected is the overwhelming need in the community for specialty care providers. DRH currently offers: podiatry, pediatric dentistry, ENT and cardiology. The lack of a general surgeon is one notable gap in specialty services. The limited number of specialty services offered by DRH has caused the patient transfer rate to be very high for a small rural hospital (avg. 100/month). Many of these patients have to drive 1.5 – 2 hours one way for specialty care in San Antonio. This places an undue hardship on our low income rural population that is 86% Hispanic. These transfers are anticipated to increase dramatically. The population of our rural community is experiencing large growth associated with the nearby Eagle Ford shale natural gas operation.

The selected milestones and metrics were chosen according to what addressed the DRH patient population needs with the highest degree of impact. Increasing specialty care capacity while ensuring proper training will improve the quality of care while avoiding future costs.
associated with untrained staff. In DY 4-5, the improvement milestones were chosen to focus on patient satisfaction with increased access to higher quality specialty care services. This keeps the focus on the patient experience, quality of care and cost.

**Project Components:**

Through “Improving Rural Access to Specialty Care”, we propose to meet all required project components, except for component B.

A. **Identify high impact/most impacted specialty services and gaps in care and coordination.**
   
   This component will be accomplished in DY 2. We plan to hire a third-party healthcare consultant to perform this specialty care gap assessment. The results of this assessment will establish a firm baseline for our project in those specialty care areas where there are gaps in coverage. Currently there are only 4 specialty care providers in the following areas: podiatry, pediatric dentistry, ENT and cardiology. A notable gap in specialty care is the lack of a general surgeon.

B. **Increase the number of residents/trainees choosing targeted shortage specialties.** This project component will not be addressed in this project. The reason this component is left out is because of the small size of the hospital (45 licensed beds) and its rural location (100+ miles southwest of San Antonio). Currently our facility does not have the resources, space or staff to provide residencies for physicians. Not only this, local housing for these residents would be extremely difficult to find, considering the recent natural gas/oil boom. Also, completing this project component is unrealistic given the few specialists available in our area to provide such training.

C. **Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention).** Our community is an underserved market considering the lack of specialty care services and its designation as a HPSA. We plan to meet this project component through two different implementation steps. First we will train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Then we will increase the number of specialist providers, clinic hours and/or procedure hours in targeted specialties. This will occur in DY 2 and DY 3.

D. **Conduct quality improvement for project using methods such as rapid cycle improvement.** We plan to meet this project component through participating in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP. These meetings will be to promote collaborative learning around shared or similar projects. We will then implement at least one “raise the floor” improvement initiatives established at the semiannual meeting per year for DY 4 and 5.

**Unique community need identification numbers the project addresses:**

- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.3 – Many residents in RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

Currently residents of DRH’s service region do not have access to most specialty services, due to severe shortage of local specialty care providers. Implementation of “Improving Rural Access to Specialty Care” address; the triple aim goals of the waiver, the RHP 6 goal of improving the health care infrastructure to better serve the Medicaid and uninsured residents of the region, and addresses a severe specialty provider shortage area. This project will help alleviate an ongoing financial hardship on our 86% Hispanic, Medicaid and uninsured population.
Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure)
(3) patient’s rating of doctor access to a specialist

Reasons/rationale for selecting the outcome measures:
The selected Category 3 outcome measure is directly linked to the improvement milestones in DY 4-5 for the 1.9.1 project option that was chosen. Implementing “Improving Rural Access to Specialty Care” is directly related to the patient’s view of how easy it is for him or her to access a specialist. Focusing on this outcome will help the Medicaid and uninsured population have better and better access to local specialty care. This will directly impact patients, most of whom cannot afford to travel 100 miles or more into San Antonio for care. Also, patients are more likely to receive specialty care faster than if they had scheduled an appointment at a large facility in San Antonio. DRH understands and is better equipped to meet the needs of its population than specialty care providers 100 miles to the northeast in San Antonio.

Relationship to other Projects:
The primary way this project supports, reinforces and enables other projects in the RHP is its contribution towards the RHP 6 goals. Implementing “Improving Rural Access to Specialty Care” will improve the health care infrastructure and better serve our Medicaid and uninsured population. It will do this by expanding specialty care capacity to reduce a severe shortage of providers while focusing on patient satisfaction. Increasing the capacity for local specialty care providers and training for their staff will help develop a coordinated care delivery system. This is another RHP 6 goal. Most importantly, this project achieves the triple aim waiver goals of assuring patients receive high-quality and patient-centered care in the most cost effective way.

Related Category 4 Population-focused measures:
RD-3: Potentially Preventable Complications (PPCs)
RD-4: Patient-centered Healthcare

Relationship to Other Performing Providers’ Projects in the RHP:
University Hospital, PA: 1.9
Baptist Medical Center, PA: 1.9
Methodist Hospital PA: 1.9
Uvalde Memorial Hospital, PA: 1.2
Medina Regional Hospital, PA: 1.1
Frio Regional Hospital, PA: 1.1
Val Verde Regional Medical Center, PA: 1.9
UTHSCSA, PA: 1.9

Plan for Learning Collaborative:
DRH plans to participate in an RHP-wide learning collaborative with other providers with similar projects. “RHP 6 is committed to transforming health care in our region and throughout the state. Given the large number and value of projects proposed for our region, University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives.” Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
-Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

DRH plans to be a significant part of learning collaboratives with other performing providers with similar projects.

**Project Valuation:**

Of all potential DSRIP projects considered, DRH has chosen “Improving Rural Access to Primary Care”. This project scored high in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment. These categories were assigned by University Health System, the RHP 6 anchor.

In addition to valuing potential projects based on these 4 areas, the project selected fills the most pressing and important community healthcare need. The population of the service region is growing rapidly. Currently, an average of 100 patient transfers/month to San Antonio (over 100 miles+ away) are occurring at DRH. This is number is expected to climb exponentially as the population grows to accommodate workers moving for the Eagle Ford shale natural gas boom. The population needs local providers of high impact specialty care services to remain healthy, lower their costs and overcome geographic isolation.

A detailed outline of the costs associated with each component, including the cost of recruiting specialty providers, cannot be reliably assessed at this time. This will be assessed after process milestone 1.1 is achieved. Achievement of this milestone will identify high need specialty care shortages and recommend specialty care services with the most impact for the patient population.
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<tr>
<th>112690603.1.1 PASS 1</th>
<th>1.9.1</th>
<th>1.9.1.ACD</th>
<th>1.9.1 Expand high impact specialty care capacity in most impacted medical specialties: Improving Rural Access to Specialty Care</th>
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<td>Dimmit Regional Hospital</td>
<td>TPI - 217884001</td>
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<td>Related Category 3 Outcome Measure(s):</td>
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<td>3.IT-6.1</td>
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<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
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<td><strong>Milestone 1</strong> [P-1]: Conduct a specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Baseline: Current specialty services: podiatry, pediatric dentistry, ENT and cardiology. Most notable gap is lack of a general surgeon. However, baseline will be established upon completion of the specialty care gap assessment in DY 2. Goal: Establish a baseline with gaps in specialty care documented. Identify high impact specialty care services to fill gaps and meet population needs. Data Source: Specialty care gap/needs assessment</td>
<td><strong>Milestone 3</strong> [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, process and technology. Baseline: 50% of staff and providers trained in referral guidelines, process and technology. Goal: 98% of staff and providers trained in referral guidelines, process and technology. Data Source: Specialty care personnel trained and curriculum of training. Milestone 3 Estimated Incentive Payment: $698,713.5</td>
<td><strong>Milestone 5</strong> P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1: 21.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline: 0 Goal: attend 2 collaborative learning RHP meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Metric 2: Implement the “raise the floor” improvement initiatives established at the semiannual meeting</td>
<td><strong>Milestone 8</strong> P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1: 21.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline: 2 in DY 4 Goal: attend 2 collaborative learning RHP meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Metric 2: Implement the “raise the floor” improvement initiatives established at the semiannual meeting</td>
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**Milestone 2**

[P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties.

**Metric 1** [P-2.1]: Training of staff and providers on referral guidelines, process and technology. **Numerator**: Number of staff and providers trained and documented. **Denominator**: Total number of staff and providers qualified for training.

**Baseline**: 0

**Goal**: Train at least 50% of staff and providers on referral processes, guidelines and technology.

**Data Source**: Log of staff and provider training.

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**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for high impact/most impacted medical specialties.

**Metric 1** [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. **Numerator**: Number of specialist providers in targeted specialties over baseline or change in number of specialist providers in targeted specialties. **Denominator**: Total number of specialist providers in targeted specialties.

**Baseline**: Currently 4 specialist providers. Baseline may change if any DY 2 provider changes occur.

**Goal**: Recruit at least 1 new specialist provider in the high impact/most impacted medical specialties identified by achievement of [P-1] milestone in DY 2.

**Data Source**: Log of specialty care personnel trained and curriculum of training.

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<th>Milestone 5</th>
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**Milestone 5**

**Goal**: Implement at least 1 “raise the floor” improvement initiative.

**Data Source**: Documentation of “raise the floor” improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implement the initiative after the meeting.

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**Milestone 6**

**Goal**: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-23.1]: Documentation of increased number of visits; demonstrate improvement over prior reporting period.

**Baseline**: TBD in DY 3 after accomplishment of I-22.

**Goal**: 2000 total patient visits in DY 4 to specialist provider(s) recruited in DY 3.

**Data Source**: EMR, appointment schedule.

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**Milestone 7**

**Goal**: 2500 total patient visits in DY 5 to specialist provider(s) recruited in DY 3.

**Data Source**: EMR, appointment schedule.
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<tbody>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $467,163</td>
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**Milestone 7**

[I-27]: Patient satisfaction with specialty care services.  
**Metric 1** [I-27.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Numerator: Number of surveys distributed during the reporting period. Denominator: Total number of specialty care visits during the reporting period.  
**Baseline:** 0  
**Goal:** At least 60% of specialty care patients receive survey.  
**Data Source:** Documentation of survey distribution, EHR  
**Metric 2** [I-27.3]: Survey response rate. Numerator: Number of survey responses. Denominator: total number of surveys distributed.  
**Baseline:** 0  
**Goal:** A 17% average survey response rate.  
**Data Source:** CAHPS; documentation of survey distribution and EHR  

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<td>Milestone 9 Estimated Incentive Payment: $385,917.3</td>
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[I-27]: Patient satisfaction with specialty care services  
**Metric 1** [I-27.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey.  
**Baseline:** 60% received survey  
**Goal:** At least 85% of patients receive a survey.  
**Data Source:** Documentation of survey distribution, EHR  
**Metric 2** [I-27.3]: Survey response rate. Numerator: Number of survey responses. Denominator: total number of surveys distributed.  
**Baseline:** 17% achieved in DY 4  
**Goal:** A 22% average response rate.  
**Data Source:** CAHPS; documentation of survey distribution and EHR.
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,237,598**
Identifying Project and Provider Information:
Title: 1.6.2 – Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.
Unique RHP ID#: 112690603.1.2 – PASS 2
Performing Provider: Dimmit Regional Hospital (previously Dimmit County Memorial Hospital)
Performing Provider TPI: 217884001

Project Summary:
Provider Description: Dimmit Regional Hospital (previously Dimmit County Memorial Hospital) is a 45-bed hospital located in Carrizo Springs, TX. The hospital serves Dimmit County, population approximately 10,000, across 1,329 square miles.
Intervention(s): This project will introduce an urgent medical advice line while simultaneously creating a “fast track” triage system for the ED. These changes will decrease ED wait times.
Need for the project: Currently the average time between when an ED patient arrives and when he or she is seen by a physician is 90 minutes. This time has the potential to increase as the population continues to grow in response to nearby oil and natural gas operations. We are already seeing more trauma cases in the ED as a result of this growth and type of employment. A higher number of trauma cases results in a longer wait for ED patients with non-emergent medical conditions.
Target population: The target population is our ED patients with non-emergent conditions. Our target population also includes patients who could be seen in a primary care clinic instead of the ED for their urgent medical condition. Providing greater access to same-day primary care appointments through an urgent medical advice line would decrease ED volume. Our current Medicaid inpatient utilization rate is 67% and our low income utilization rate is 70%. Approximately 32% of our population is uninsured.
Category 1 or 2 expected patient benefits: The project will reduce the average “door to doc” time in our ED from 90 minutes to 60 minutes by the end of DY 4. In DY 4, we have set a goal to reduce this baseline 90 minute wait time (current DY 2 baseline time) to no longer than an average of 45 minutes. Typically our ED averages 11,000 admissions per year. If each of these patients wait for 90 minutes (our current average), this amounts to 16,500 hours or 1.88 years of total wait time to see a doctor. However, if by DY 5 we cut this wait time to an average of 45 minutes, this equates to a 50% reduction in “door to doc” time in our ED. This translates into an additional 8,250 hours or 344 total days our ED patients have outside of our emergency room. This has a very real impact on the health and well-being of our population. In addition to this benefit, lower acuity patients will utilize a new urgent medical advice line while higher acuity patients will benefit from a more effective and efficient ED.
Category 3 outcomes: IT-9.2 – Our goal is to reduce all ED visits. The actual percent reduction in ED visits realized in DY 4 and DY 5 is TBD in DY 3.

Project Description:
Dimmit Regional Hospital proposes to reduce ED wait times by reducing the number of ED patient visits for non-emergent conditions through a new urgent medical advice line and through a new ED fast-track system.
Dimmit Regional Hospital (DRH) is seeking to improve access to urgent care for its rural community. DRH is a 45 bed non-profit public hospital owned by Dimmit Regional Hospital District. It is located approximately 100 miles southwest of San Antonio. Currently the rural population is experiencing a large growth in population, due to the nearby Eagle Ford shale
natural gas and oil operations. The nature of the work performed and the work environment these individuals are exposed to has caused a dramatic increase in the number of ED patients with acute, emergent conditions. This has resulted in excessive wait times for ED patients with non-emergent conditions.

The proposed project will develop clinical protocols for an urgent medical advice line within the first year (DY 2). A vetting process will also be established for these protocols within RHP 6. After these protocols are developed, ED nurses will be trained on these clinical protocols. ED nurses will be assigned to staff this urgent medical advice line. Finally, in this first year an assessment will be conducted on ED workforce needs for an ED “fast track” system. The plan for such a system will be developed along with its implementation timeline.

During the second year of the project (DY 3), ED patients will be informed and educated with regards to the urgent medical advice line. The goal is to have at least 10% of ED patients seen in this year informed about the urgent medical advice line, with at least 5% who utilize it in the first year. Also, the number of mid-level providers in the ED will be increased to support the implementation of the ED “fast track” system during this year.

In the third and fourth years of the project (DY 4 – DY 5), the project performance will be measured based on advice line utilization and the average “door to doc” ED patient waiting times. It is our goal to increase utilization of the advice line while decreasing average “door to doc” times substantially during these two years.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

- Increase access to primary care in the local rural community, currently a HPSA
- Reduce utilization of the ED by patients with non-emergent conditions
- Reduce the average time spent waiting for care by ED patients
- Improve the patient experience and quality through reducing cycle time while improving provider productivity.

The project meets the following regional goals:

- Work together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered care, in the most effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
- Further develop and maintain a coordinated care delivery system.
- Improve outcomes while containing cost growth.

This project and its goals contribute toward achieving regional goals. The project will achieve these through educating patients on the benefit of utilizing primary care services (clinics and the urgent medical advice line) instead of ED services. Nurses will triage patients to primary care clinics based on developed, vetted clinical protocols. Also, it will improve patient satisfaction and quality of care through reduced wait times. This will improve efficiency and outcomes while reducing cost. Finally the urgent medical advice line will increase access to primary care advice and emergent care (when necessary – ED fast track) during times when local primary care clinics are closed.

**Challenges:**

Currently, the average time between patient arrival in the ED and being seen by a physician is 90 minutes. Without an urgent medical advice line coupled with an ED “fast track” system, this average wait time is expected to increase dramatically. Already ED physicians are experiencing a
higher rate of trauma patients. This is a direct result of working conditions experienced by those employed by companies taking advantage of the local Eagle Ford natural gas and oil boom. This high rate of trauma patients (expected to increase with the projected growth of the population) has already caused ED patients with non-emergent conditions to experience wait times that are excessive.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcomes for Dimmit Regional Hospital and for our patients are: a 50% reduction in average patient “door to doc” time in the ED, at least 15% of DY 5 ED patients have used the urgent medical advice line on at least one or more occasions, and at least 45% of patients who respond to the urgent medical advice line survey report advice was appropriate.

This project is related to regional goals because it will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region. It will reduce the cost to the patient, the hospital and the payer. This project will achieve this through conducting quality improvement projects suggested during the semi-annual RHP 6 learning collaboratives and continual project evaluation.

Starting Point/Baseline:
Baselines for Process Milestones are effectively 0 at this time as this project is new for Dimmit Regional Hospital. There is not currently any similar project in our service region as we are the only hospital within our rural community. Baselines for process milestones extending to DY 4 and DY 5 will be set in DY 2 and/or DY 3.

Baselines for Improvement Milestones are listed below:
The average ED “door to doc” time is approximately 90 minutes. The [I-13] - 0, The baseline will be established by the end of DY 2 after the ED nurse advice line has been implemented [I-15] - 0, no advice line currently exists. Survey would begin in DY 4 [I-X] - 90 minute ED patient “door to doc” time average in DY 2.

Rationale:
A reduced ED waiting time is important because it reduces the number of patients who leave without being seen (LWOBS). This ensures compliance under EMTALA. An urgent medical advice line will reduce wait times by providing a source of medical advice for patients with non-emergent medical conditions. Our hospital is located within a designated Healthcare Professional Shortage Area (HPSA). This creates a high percentage of patients that do not have access to a primary care physician. However, the area is growing and primary capacity expansion is moving forward. An urgent medical advice line will facilitate access to primary while also aiding patients during times when primary care clinics aren’t open.

Despite the high potential for impact the urgent medical advice line will have on our population, Dimmit Regional Hospital anticipates a regular flow of non-emergent patients in the ED. This is due to a 32% average rate of uninsured residents combined with the low per capita income level throughout our rural community. Also, the increase in primary care capacity will be gradual; it will take time for the supply of primary care physicians to catch up to the high demand in our community. The selected milestones and metrics were chosen according to what addressed the DRH patient population needs with the highest degree of impact.

Project Components:
  a. Develop a process (including a call center) that in a timely manner triages patients
seeking primary care services in the ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received. This component will be included in the project by achieving process milestones: P-1, P-3, P-5, and P-6. A patient satisfaction survey will be sent to patients who utilize the nurse advice line with goals to improve scores in DY 4 and DY 5 (improvement milestone I-15).

b. Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients. This component will be included in the project by the achievement of these process milestones: P-1, P-3, P-5, and P-6.

c. Conduct quality improvement for project using methods such as rapid cycle improvement. This component will be included in the project by the achievement of these process and improvement milestones: P-1, I-13, I-15 and I-X. The achievement of improvement milestone I-X is especially critical to reducing cycle time of ED processes, impacting patient wait times.

Unique community need identification numbers the project addresses:

- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.3 – Many residents in RHP 6 lack access to medical and dental care due to high rates of un-insured and health care provider shortages.

Currently residents of DRH’s service region lack sufficient access to primary care services as they live within a rural community and a designated HPSA. This project would be the first of its kind in our region. An urgent medical advice line, if successful, has the potential to be adopted by rural hospital in nearby communities. This would decrease ED admits for non-emergent conditions throughout the rural service areas of RHP 6. Implementation of this project addresses; the triple aim goals of the waiver, the RHP 6 goal of improving the health care infrastructure to better serve the Medicaid and uninsured residents of the region. This project will help alleviate an ongoing financial hardship on our 86% Hispanic, Medicaid and uninsured rural population.

Related Category 3 Outcome Measure(s):

OD-9: Right Care, Right Setting
IT-9.2 - Reduce all unnecessary ED visits (including ACSC)

Reasons/rationale for selecting the outcome measures:

The selected Category 3 outcome measure is directly linked to the improvement milestones in DY 4-5: [I-13], [I-15], [I-X]. The [I-13] milestone ensures that utilization of the urgent medical advice line by ED patients is increasing over time. This will lead to fewer unnecessary ED admits or fewer patients who visit the ED for non-emergent conditions and higher community utilization of primary care services. The [I-15] milestone ensures that patients’ trust in the advice provided by the nurse is increasing over time. This will lead to fewer unnecessary ED admits or fewer patients who visit the ED for non-emergent conditions and higher community utilization of primary care services. Also this milestone will provide the opportunity to evaluate the performance of nurses assigned to staff the urgent medical advice line, including how well they are following established clinical protocols. The [I-X] milestone will ensure that ED wait times
are significantly reduced. This will allow for higher quality care, higher patient satisfaction and reduced ED length of stay. This will free up ED physicians to spend more time on caring for patients with emergent conditions. The “fast track” system used to achieve a shorter cycle time (decreased patient waiting times) will also allow for an opportunity to inform patients of the urgent medical advice line.

**Relationship to other Projects:**
The primary way this project supports, reinforces, enables and is related to other projects and interventions within the RHP plan are through contribution to RHP 6 goals. The project will achieve these by educating patients on the benefit of utilizing primary care services (clinics and the urgent medical advice line) instead of ED services. Nurses will also triage patients to primary care clinics based on developed, vetted clinical protocols. Also, it will improve patient satisfaction and quality of care through reduced wait times. This will improve efficiency and outcomes while reducing cost.

Related Category 4 Population-focused measures:
- **RD-1: Potentially Preventable Admissions**
- **RD-4: Patient-centered Healthcare**
- **RD-5: Emergency Department**

**Relationship to Other Performing Providers’ Projects in the RHP:**
We are not aware of any other providers in the RHP proposing similar projects.

**Plan for Learning Collaborative:**
DRH plans to participate in an RHP-wide learning collaborative with other providers with similar projects. RHP 6 is committed to transforming health care in our region and throughout the state. Given the large number and value of projects proposed for our region, University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives. Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
- Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

DRH plans to be a significant part of learning collaboratives with other performing providers with similar projects.

**Project Valuation:**
This project scored high in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment. Dimmit Regional Hospital also values each project based on the following factors: the potential impact on health of our population, the resources necessary to implement the project, and level of improvement.
anticipated in overall patient satisfaction. Dimmit Regional Hospital also took into account the extent to which reducing ED waiting times and reducing the volume of non-emergent ED patient visits would potentially meet the goals of the region and the Waiver.
<table>
<thead>
<tr>
<th>112690603.1.2 PASS 2</th>
<th>1.6.2</th>
<th>1.6.2.ABC</th>
<th>1.6.2 – Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.</th>
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</thead>
<tbody>
<tr>
<td>Dimmit Regional Hospital</td>
<td></td>
<td></td>
<td>TPI - 112690603</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>112690603.3.2</td>
<td>3.1T-9.2</td>
<td>ED appropriate utilization: Reduce all ED visits</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 1 [P-1]: Establish clinical protocols for an urgent medical advice line within 4 years of the demonstration period with a vetting process within the RHP. Metric 1 [P-1.1]: Submission of complete protocols. Baseline: 0, There is not currently a medical advice line in place and clinical protocols for one have not been developed for our community. Goal: Submission of complete protocols for urgent medical advice line. Data Source: Protocol documents</td>
<td>Milestone 5 [P-6]: Inform and educate patients on the nurse advice line Metric 1 [P-6.1]: Number of percent of ED patients with non-emergent conditions informed/educated. Numerator: Number of ED patients with non-emergent conditions informed/educated. Denominator: Number ED patients with non-emergent conditions who visited the ED during DY 3. Baseline: 0, A nurse advice line does not currently exist. Goal: At least 10% of DY 3 ED patients with non-emergent conditions were contacted and informed/educated about how to access and utilize the nurse advice line</td>
<td>Milestone 8 [P-6]: Inform and educate patients on the nurse advice line Metric 1 [P-6.1]: Number of percent of ED patients with non-emergent conditions informed/educated. Numerator: Number of ED patients with non-emergent conditions informed/educated. Denominator: Number ED patients with non-emergent conditions who visited the ED during DY 4. Baseline: 0, A nurse advice line does not currently exist. Goal: At least 15% of DY 4 ED patients with non-emergent conditions were contacted and informed/educated about how to access and utilize the nurse advice line</td>
<td>Milestone 12 [P-6]: Inform and educate patients on the nurse advice line Metric 1 [P-6.1]: Number of percent of ED patients with non-emergent conditions informed/educated. Numerator: Number of ED patients with non-emergent conditions informed/educated. Denominator: Number ED patients with non-emergent conditions who visited the ED during DY 5. Baseline: 0, A nurse advice line does not currently exist. Goal: At least 20% of DY 5 ED patients with non-emergent conditions were contacted and informed/educated about how to access and utilize the nurse advice line</td>
</tr>
</tbody>
</table>

Milestone 1 Estimated Incentive Payment: $ 90,298.5
### Milestone 2

#### [P-3]: Train nurses on clinical protocols

**Metric 1** [P-3.1]: Number of nurses trained. Numerator: number of ED nurses trained at baseline. Denominator: total number of ED nurses.

- **Baseline:** 0, No clinical protocols for an urgent medical advice line have been developed.
- **Goal:** 70% of ED nurses trained in clinical protocols for urgent medical advice line.

**Data Source:** HR records

**Milestone 2 Estimated Incentive Payment:** $90,298.5

### Milestone 3

#### [P-5]: Establish a multilingual ED nurse advice line

**Metric 1** [P-5.1]: ED Nurse advice line. Numerator: Number of ED nurses designated to staff a nurse advice line. Denominator: number of ED nurses at baseline.

- **Baseline:** 0, Currently an urgent medical advice line does not exist.
- **Goal:** 2 or more ED nurses

**Data Source:** Documentation in patient record that patient was contacted and received information about accessing the nurse advice line and education about how to use the nurse advice line.

**Milestone 5 Estimated Incentive Payment:** $139,770.67

### Milestone 6

#### [I-13]: Increase in the number of patients that accessed the nurse advice line

**Metric 1** [I-13.1]: Utilization of nurse advice line. Numerator: Number or percent of ED patients that access the nurse advice line. Denominator: ED patients.

- **Baseline:** 0, The baseline will be established by the end of DY 2 after the ED nurse advice line has been implemented.
- **Goal:** At least 5% of DY 3 ED patients have used the nurse advice line ≥1 time.

**Data Source:** phone, encounter and/or appointment scheduling software records.

**Milestone 8 Estimated Incentive Payment:** $106,287.25

### Milestone 9

#### [I-13]: Increase in the number of patients that accessed the nurse advice line

**Metric 1** [I-13.1]: Utilization of nurse advice line. Numerator: Number or percent of ED patients that access the nurse advice line. Denominator: ED patients.

- **Baseline:** 0, The baseline will be established by the end of DY 2 after the ED nurse advice line has been implemented.
- **Goal:** At least 10% of DY 4 ED patients have used the nurse advice line ≥1 time.

**Data Source:** phone, encounter and/or appointment scheduling software records.

**Milestone 9 Estimated Incentive Payment:** $106,287.25

### Milestone 10

#### [I-15]: Increase patient satisfaction

- **Data Source:** Documentation in patient record that patient...
<table>
<thead>
<tr>
<th>Milestone 3 Estimated Incentive Payment: $ 90,298.5</th>
</tr>
</thead>
</table>
| **Milestone 4**  
[P-X]: Conduct an ED workforce needs assessment and develop an ED “fast-track” implementation plan.  
**Metric 1** [P-X.1]: ED workforce needs identified with a timeline for ED fast-track implementation.  
**Baseline**: 0, ED workforce needs baseline will be established by assessment. An implementation plan for ED fast-track does not exist.  
**Goal**: Create a viable ED fast-track implementation plan based on ED workforce needs.  
**Data Source**: Needs assessment documentation and planning documentation |
| Milestone 6 Estimated Incentive Payment: $ 139,770.67 |
| **Milestone 7**  
[P-X]: Implement a “fast track” for ED patients with non-emergent conditions.  
**Metric 1** [P-X.1]: ED fast track implemented  
**Baseline**: 0, an ED fast track does not currently exist.  
**Goal**: Establish an effective ED fast track for ED patient with non-emergent conditions focused on reducing door to decision time.  
**Data Source**: HR documentation of increased PA or NP, ED providers. ED patient wait time log demonstrating a decrease. |
| Milestone 8 Estimated Incentive Payment $ 139,770.67 |
| **Milestone 9**  
[P-X]: Increase satisfaction  
**Metric 1** [I-15.1]: Increase surveyed patients who believed the advice provided was appropriate  
**Baseline**: 0, no advice line currently exists. Survey would begin in DY 4.  
**Goal**: At least 45% of DY 4 survey respondents report that the advice provided was appropriate.  
**Data Source**: Patient satisfaction surveys |
| Milestone 10 Estimated Incentive Payment $ 106,287.25 |
| **Milestone 11**  
[I-X]: Decrease time spent by ED patients waiting to see a doctor.  
**Metric 1** [I-X.1]: Average ED patient “door to doc” time. Time from patient arrival in the ED to the time the patient is seen by a physician.  
**Baseline**: 90 minute ED patient “door to doc” time average in DY 2.  
**Goal**: Reduce “door to doc” time to a 45 minute average. (Average 11,000 ED patient visits per year, prior to DY 2) |
| Milestone 12 Estimated Incentive Payment $ 106,287.25 |
| **Milestone 13**  
[I-X]: Decrease time spent by ED patients waiting to see a doctor.  
**Metric 1** [I-X.1]: Average ED patient “door to doc” time. Time from patient arrival in the ED to the time the patient is seen by a physician.  
**Baseline**: 90 minute ED patient “door to doc” time average in DY 2.  
**Goal**: Reduce “door to doc” time to a 45 minute average. (Average 11,000 ED patient visits per year, prior to DY 2) |
| Milestone 14 Estimated Incentive Payment $ 90,954 |
| **Milestone 15**  
[I-X]: Decrease time spent by ED patients waiting to see a doctor.  
**Metric 1** [I-X.1]: Average ED patient “door to doc” time. Time from patient arrival in the ED to the time the patient is seen by a physician.  
**Baseline**: 90 minute ED patient “door to doc” time average in DY 2.  
**Goal**: Reduce “door to doc” time to a 45 minute average. (Average 11,000 ED patient visits per year, prior to DY 2) |
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<thead>
<tr>
<th>Milestone</th>
<th>Estimated Incentive Payment (Average)</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>Milestone 4</td>
<td>$90,298.5</td>
<td>(Average 11,000 ED patient visits per year, prior to DY 2)</td>
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<tr>
<td></td>
<td></td>
<td>Data Source: Patient records, ED arrival time log book, physician documentation.</td>
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<tr>
<td>Milestone 11</td>
<td>$106,287.25</td>
<td>Milestone 15 Estimated Incentive Payment $90,954</td>
</tr>
<tr>
<td>Milestone 15</td>
<td>$90,954</td>
<td>Data Source: Patient records, ED arrival time log book, physician documentation.</td>
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<td>Year 2</td>
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<td>Year 3 Estimated Milestone Bundle Amount: $419,312</td>
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<td>Year 3</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $425,149</td>
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<td>Year 4</td>
<td>$425,149</td>
<td>Year 5 Estimated Milestone Bundle Amount: $363,816</td>
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<tr>
<td>Year 5</td>
<td>$363,816</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,569,472</strong></td>
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Identifying Project and Provider Information:
Title: 1.1.2 Expand Primary Care Capacity
Unique RHP ID#: 112688002.1.1 – PASS 1
Performing Provider: Frio Regional Hospital
Performing Provider TPI: 112688002

Project Summary:
Provider Description: Frio Regional Hospital is a 22 bed hospital in Pearsall, Texas serving the people of Frio and LaSalle Counties with a combined population of about 25,000.
Intervention(s): This project will expand access to primary care by recruiting additional physicians, building new clinic space and increasing efficiencies in clinic offices.
Need for the project: There is a serious lack of primary care in these counties, resulting in a number of inefficiencies in healthcare delivery. Chronic care management results with a high percentage of patients with uncontrolled diabetes, hypertension, and heart disease.
Target population: The target population is our patients needing primary care appointments without having to wait for 4 – 6 weeks. About 1/3 of our community lives below the poverty line, and we expect that they will be better able to access primary care.
Category 1 or 2 expected patient benefits: We seek to increase office times so that patients can access care after normal business hours and on weekends. It is hoped to decrease the wait time for an appointment by at least 1 week.
We anticipate in DY 4 for the new primary care provider we recruit in DY 2 to have an estimated panel size of at least 1,800 patients. With this panels size, we are setting a goal in DY 4 of 3,600 visits or 1,800 patients X average of 2 visits per patient = 3,600 visits. However, since the new primary care provider’s panel size may grow at a slower rate than anticipated, we will also lengthen clinic hours. Patient visits during these extended hours will be included in this total. In DY 5 we expect our new primary care provider’s panel to have grown to at least 2,000 patients. Resulting from this panel size we expect at least 4,000 visits in DY 5. Again, visits made during extended clinic hours will be included.
Category 3 outcomes: Our goals are to increase the number of diabetes management measures such as retinal eye examination, foot examination and microalbumin/neuropathy test.

Project Description:
DSRIP Project 1.1.2, “Expand Primary Care Capacity” is important to Frio County because of poor access to primary care in our area. Many untreated conditions increase in acuity. This overloads available emergency services.

Project Goals:
The project will increase opportunities to obtain primary care by increasing the number of physicians, physician assistants and nurse practitioners. This necessitates an increase in available office space to house clinics. Additional training will be provided to clinic office staff to enable better scheduling of patient appointments and reducing the number of “no shows”. Improving for primary care, will enable patients to avoid the emergency room, resulting in fewer transfers to tertiary facilities for additional services.

This project will meet the following regional goals:
- The project will encourage working together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered, in the most effective ways
• The project will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
• The project will further develop and maintain a coordinated care delivery system. Finally the project will improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents through increasing primary care capacity. The project will increase capacity by expanding the number of primary care clinics and/or expanding existing space/hours. The project develops and maintains a coordinated care delivery system through improvements in EHR, HIT and communication systems. The project improves outcomes while containing cost growth by providing access to primary care providers. Patients who now rely on the emergency room for primary care will then have access to a less costly and more appropriate mode of care.

Challenges:
Frio County is designated as a “Health Professional Shortage Area.” Because of the payer mix, it has been difficult to recruit physicians as well as other health professionals. This presents a major challenge. Frio Regional Hospital will increase its’ efforts to recruit physicians, employing professional recruiters to do so. Another obstacle is the lack of training among clinic employees on scheduling patients. As electronic medical records are implemented, and additional training is provided, this will improve efficiencies. There is also a lack of available clinic space, so either new construction or refurbishing of existing space is necessary.

Expected Outcome for Provider and Patients in 5 Years:
Our aim is to improve the ability of patients to access primary care by increasing the numbers of physicians and mid-level providers, improving clinic staff efficiency and providing more clinic space. Achieving this goal should reduce our non-emergent ED patient volume by 15 to 20% by the end of DY 5. Clinical outcomes we expect to be significantly improved in five years are those related to the management of prevalent chronic diseases specific to our population. We have reflected this expected patient benefit and impact by selecting Category 3 improvement targets centered on improving diabetes care by increasing: retinal eye exams, foot exams, microalbumin/nephropathy screenings.
### Starting Point/Baseline:

Between October 1, 2011 and September 30, 2012 area primary care clinics had patient visits of roughly 38,000. The community is served by 6 FTE Family Practice Physicians and 1 FTE OB/Gyn. Given the population of Frio County of 16,163 the number of family practitioners should number 18 FTE’s. Based on these calculations, another 12 Family Practitioners are needed. There are 2 Physician Assistants and 2 Nurse Practitioners. In addition, there are 26 employed by these primary care clinics. Some offices utilize electronic medical records and some do not. None of those mentioned are trained in this project.

### Rationale:

Frio County is medically underserved as are most counties in RHP 6. There is a shortage of physicians and other health professionals. Our community has a significant amount of diabetes, obesity, heart disease, and hypertension. Untreated, these chronic conditions lead to further complications. A main source of health education is the clinic office. With a physician shortage, it is difficult to address and manage chronic conditions. This is further complicated by high levels of uninsured. Thirty percent of the population lives below the poverty line. Many work for small businesses that cannot afford to provide health care benefits. This translates to 25% of the population being uninsured. In general the citizens of the area tend to less educated and have a lower per capita income.

The statistics of Frio County are consistent with RHP 6. This region is noted for high uninsured rates and poor health outcomes. Our population is 54% Hispanic and 37% Anglo. In Frio County it is approximately 76% Hispanic and 24% Anglo. Geographically, around 61% of RHP is rural and “feeds” the tertiary systems in San Antonio. Because of the lack of primary care management, many acute worsen and require transfers to tertiary center emergency departments.

The region is undergoing an “oil boom” which has attracted new people to the area. It is expected to tax existing resources to expand services. The area has been challenged in attracting primary care physicians and mid-level practitioners. An expansion in healthcare coverage could have a significant impact on making recruitment more attractive.

To reiterate from earlier, there are three aspects to our project:

A) Recruit primary care physicians and mid-level practitioners to allow for expanded and extended hours of service.

B) Increase Clinic Space to accommodate the increase in medical professionals

C) Provide training to Clinic Staff to enable greater efficiencies in scheduling and providing appointments, including extended office hours for follow-up care.

The project addresses the above stated needs for our area and RHP 6, especially:

- CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care providers shortages.

Process milestones selected were:

1. P-4 – Expand the hours of a primary care clinic, including evening and/or weekend hours, and P-4.1 will be the metric increasing hours over the baseline. Current operating hours for the area primary care clinics is 9:00 AM to 5:00 PM Monday through Friday. There are no appointments available after hours or on weekends.
2. P-5 – Train, hire additional primary care providers and staff as evidenced by P-5.1 Documentation of increased numbers of providers and staff in Pearsall, Dilley and Cotulla.

The improvement target selected is (1.1.2) I-12 with the milestone to be the increase in clinic visits as evidenced by improved access.

I-12.1 – Will be documentation of increased visits
I-12.2 – Documentation of the number of unique patients or size of patient panels.

This will significantly improve the general standards of care by management of chronic conditions. Better access to medical care will increase opportunities to educate patients on becoming more compliant with treatment. The cost of not managing chronic conditions is reflected in use of the emergency services both locally and by transfer. Specifically, diabetes management is being targeting as a response to community input. It is estimated that nearly a third of the population is either diabetic or at risk of developing diabetes. Better management will reduce the overall cost of providing care.

**Related Category 3 Outcome Measures(s)**

We have chosen 3 non-stand- alone measures from Category 3:

Outcome Domain – 1 (Primary Care and Chronic Disease Management)

IT – 1.12 Diabetes Care; Retinal Eye Exam
    1.13 Diabetes Foot Care exam
    1.14 Diabetic Care: Microalbumin / Neuropathy

Frio County has a high incidence of diabetes. This condition creates complication in other conditions causing a strain on local resources. Increased access to primary care should result in better management of diabetes and its complications.

**Relationship to other Projects:**

1.1.2 – Expanding Primary Care Capacity provides a foundation to numerous other 1115 Waiver Projects across various categories. Without proper access to primary care almost any of the other projects would be difficult to accomplish. It relates to other projects as follows:

    2.2 - Expansion of the chronic care management model seeks to reduce unnecessary acute and emergency room utilization by of easy access to primary care. Primary care can better manage chronic conditions such as hypertension, obesity and diabetes. Timely screenings identify conditions at an early stage that permit better management and leads to a more efficient use of resources.

    2.3 - Redesign Primary Care – Expansion of the chronic care management model above places more demands on PCP’s and their clinics to provide easy access. Timely screening for early detection of chronic conditions requires efficient scheduling. Expansion of primary care capacity increases the likelihood of this outcome.

    2.4 - “Redesign to improve Patient Experience” depends upon easy access to primary care. A major frustration is the long wait time for appointments, up to 6 weeks. Expanding primary care capacity reduces wait times, making it easier for patients to remember appointments. “No shows” decrease the patient experience.

Category 1.1.2 “Increasing Training of Primary Care Workforce” directly relates to expanding
primary care capacity in that an adequate primary care physician staff with support staff enables the primary care physician and mid-level providers to see more patients and schedule necessary screenings.

1.3 – “Implement a Chronic Disease Management Registry” indirectly relates in that chronic disease requires adequate primary care to manage the chronic disease.

1.10 – “Enhance Performance Improvement and Reporting Capacity”. Performance improvement processes will be integrated to the expansion of primary care capacity and the category 3 outcomes of screenings for diabetic patients. Since these activities are major component to clinic efficiency, education will be provided to physicians and their staffs.

<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
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<tbody>
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<thead>
<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>Out of all potential DSRIP projects considered, Frio Regional Hospital has chosen DSRIP Project 1.1.2, “Expand Primary Care Capacity”. This project received a score of 5 on a scale of 1-5 in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment.</td>
</tr>
</tbody>
</table>

This project will affect all citizens of Frio County. It will have a positive impact on neighboring communities especially San Antonio, in that local primary care will reduce the need for transfers to that community. It will allow patients to seek care locally and avoid the complications resulting from unmanaged chronic conditions. Frio Regional Hospital is the main provider of acute care in Frio County. These efficiencies will positively impact Frio Regional Hospital along with the rest of our community.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome</th>
<th>Measure(s):</th>
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<tbody>
<tr>
<td>112688002.3.1</td>
<td>112688002.3.2</td>
<td>112688002.3.3</td>
</tr>
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</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**

- **[P5]:** Train/hire additional primary care providers and staff.
- **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff.
- **Baseline:** Six physicians, 2 mid-levels, 4 full-time schedulers, 2 FTE Administration, 26 full-time staff.
- **Goal:** Add one additional physician and/or mid-level; add one scheduler, hire one additional full-time Administrator and increase staff.
- **Data Source:** Hospital reports, policy, contracts, or other documentation

**Milestone 1 Estimated Incentive Payment:** $319,209

**Year 2 Estimated Milestone Bundle Amount:** $319,209

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 2**

- **[P-4]:** Expand primary care clinic availability by 12 hours including evening and/or weekend hours.
- **Metric 1 [P-4.1]:** Increased number of primary care clinic hours over baseline.
- **Baseline:** Current hours; 9-5 weekdays
- **Goal:** Extended hours on some weekday evenings and weekends, with extended coverage on holidays.
- **Data Source:** Posted hours/clinic documentation.

**Milestone 2 Estimated Incentive Payment:** $370,006

**Year 3 Estimated Milestone Bundle Amount:** $370,006

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 3**

- **[I-12]:** Increase primary care clinic volume and evidence of improved access.
- **Metric 1 [I-12.1]:** Documentation of increased number of visits.
- **Baseline:** Combined DY 3 new primary care provider visit volume (recruited in DY 2) with visit volume during expanded hours (expanded in DY 3)
- **Goal:** 3,600 patient visits to new primary care provider combined with patient visits during expanded hours.
- **Data Source:** EHR

**Milestone 3 Estimated Incentive Payment:** $395,819

**Year 4 Estimated Milestone Bundle Amount:** $395,819

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 4**

- **[I-12]:** Increase primary care clinic volume and evidence of improved access.
- **Metric 1 [I-12.2]:** Documentation of increased number of visits.
- **Baseline:** Combined DY 3 new primary care provider visit volume (recruited in DY 2) with visit volume during expanded hours (expanded in DY 3)
- **Goal:** 4,000 patient visits to new primary care provider combined with patient visits during expanded hours.
- **Data Source:** EHR

**Milestone 4 Estimated Incentive Payment:** $411,798

**Year 5 Estimated Milestone Bundle Amount:** $411,798

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,496,832
Identifying Project and Provider Information:
Title: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Unique RHP ID#: 112688002.1.2 – PASS 2
Performing Provider: Frio Regional Hospital
Performing Provider TPI: 11268802

Project Summary:
Provider Description: Frio Regional Hospital is a 22 bed hospital located in Pearsall, Texas serving Frio and LaSalle Counties with a combined population of approximately 25,000.

Intervention(s): This project will implement telemedicine to provide patient consultations by a cardiologist for inpatient, outpatient and emergent situations.

Need for the project: There is no resident cardiologist and patients must wait for a visiting cardiologist or travel to San Antonio for consultation. This will provide a more timely delivery of care to our patients.

Target population: The target population is our patients needing cardiology consults. About 1/3 of our population lives below the poverty level and this program will make it easier for them to access cardiology services.

Category 1 or 2 expected patient benefits: We expect to provide 100 telemedicine cardiology consults in DY4 and 200 in DY5. The rate of consults per patient is expected to average between 1 and 2 consults per patient per year. We expect to reduce the number of transfers and improve the quality of care delivered to our inpatients.

Category 3 outcomes: We expect to reduce the number of readmissions for patients diagnosed with congestive heart failure and coronary artery disease.

Project Description:
DSRIP Project 1.7.1, “Implement telemedicine program to provide or expand specialist referral services in cardiology” is important to Frio County because of the high incidence of cardiac disease in our area. Most patients presenting in the emergency department with heart problems, must be shipped to other facilities because of the lack of cardiac assessment. The goal is to provide cardiology consults via telemedicine with a San Antonio based cardiologist in our emergency department so that patients receive care in a timely manner. Prompt and accurate diagnosis can reduce complications. Prompt treatment improves patient outcomes. It can also prevent unnecessary transfers which can overload available emergency services in San Antonio as well as ambulance services. Additional training will be provided to emergency room staff to assist the cardiologist making the diagnosis.

Frio County is designated as a “health professional shortage area”. Because of the payer mix, it has been difficult to recruit primary care physicians, not to mention cardiologists. This presents a major challenge. Frio Regional Hospital will increase its’ efforts to recruit an internal medicine physician, employing professional recruiters to do so. This will provide back-up support for the cardiologist on site. However, recruitment will take time and with the projected population growth will continue to strain the emergency department. Another obstacle is the lack of training among emergency department nursing staff in conducting cardiologist directed patient...
examination. As electronic medical records are implemented, and additional training is provided, this will improve efficiencies. There is also a lack of available space for increasing demand, so that new construction may be necessary. There have been issues with the local EMS in the past in terms of coordination care between patient pick-up and arrival at the emergency department. A new EMS has been hired by Frio County and it will be necessary to work closely with them to develop protocols. It will be necessary to better coordinate care with the local nursing home as well.

Our aim is improve the patients outcomes in cardiac events by improving the assessment process.

This project will meet the following regional goals:

- The project will encourage working together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered, in the most effective ways
- The project will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
- The project will further develop and maintain a coordinated care delivery system. Finally the project will improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents by providing access to specialists who otherwise would only be available after traveling 70+ miles to San Antonio. The project develops and maintains a coordinated care delivery system through improving the link between primary care physicians, patients and specialists. The project improves outcomes while containing cost growth by creating an alternative to specialist recruitment to our rural area. This project aims to improve outcomes through greater access to specialists, specifically reducing 30 day re-admission rates for CHF and CAD (Cat. 3 improvement targets).

Starting Point/Baseline:
Currently, there is no on-site specialist assessment of patients in our emergency department. Consultations occur between the emergency room physician and the appropriate physician in the facility accepting the referral. We have a cardiologist who visits the community every week and would like to provide assessments via telemedicine. We have to develop appropriate training as well as policies and procedures to provide this service.

Rationale:
As evidenced in the RHP Community Needs Assessment, access to (or lack of) specialty care is a serious issue in Texas, especially in rural parts of Texas. The following Community Needs are specifically related to this project and were identified locally in Frio as well:

CN.1 Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.

Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

One of the greatest challenges across the nation and especially in RHP 6 to provide quality care in rural areas which don’t have access to specialty physicians. Frio County is medically underserved as are most counties in RHP 6 and has no resident specialists. There is a shortage of physicians and other health professionals. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to such as exist in rural areas. With a physician shortage, it is difficult to address and manage chronic conditions. This is further complicated by high levels of uninsured. Thirty percent of the population lives below the poverty line. Many work for small businesses that cannot afford to provide health care benefits. This translates to 25% of the population being uninsured. In general the citizens of the area tend to less educated and have a lower per capita income. Telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers.

The statistics of Frio County are consistent with RHP 6. This region is noted for high uninsured rates and poor health outcomes. Our population in RHP 6 is 54% Hispanic and 37% Anglo. In Frio County it is approximately 76% Hispanic and 24% Anglo. Geographically, around 61% of RHP is rural and “feeds” the tertiary systems in San Antonio. Because of the lack of primary care management, many acute worsen and require transfers to tertiary center emergency departments. Frio County has a high percentage of its population categorized having cardiac conditions. A more efficient method of processing patient through put in the emergency department will reduce unnecessary transfers and better coordinate with local primary care physicians.

The region is undergoing an “oil boom” which has attracted new people to the area. It is expected to tax existing resources to expand services. The area has been challenged in attracting primary care physicians and mid-level practitioners which has led to excessive use of the emergency department. An expansion in healthcare coverage could have a significant impact on making recruitment, both in primary care and emergency care, more attractive.

The project option selected was:

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

Required core project components:

a) Provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications

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

This will significantly improve the general standards of care provided in the emergency department. More efficient throughput will improve improvement coordination of chronic care between the primary care physicians and the emergency department.

The overall goal of the proposed telehealth projects is to reduce disparities in access, outcome, cost and satisfaction that are created by geographic barriers. Specifically, we hope to achieve the following goals:

1.) Increase the knowledge and capacity of rural primary care physicians to manage complex chronic conditions
2.) Increase patients’ timely access to specialty care and reduce geographic barriers
3.) Create the ability for specialists to provide direct patient consults to patients based at rural clinics
4.) Improve efficiency in the rural referral process by letting specialists divert unnecessary referrals and decreasing the wait time for urgent referrals
5.) Provide service in HPSA’s
6.) Enhance access to other health care services (case management, education, etc.)

**Related Category 3 Outcome Measures(s)**

We have chosen 2 stand-alone measures from Category 3:

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>IT – 3.2</td>
<td>Congestive Heart Failure 30 day readmission rate</td>
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<tr>
<td>IT – 3.6</td>
<td>Coronary Artery Disease (CAD) 30 day readmission rate</td>
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Frio County has a high incidence of diabetes which is a risk factor for heart trouble. This condition creates complications causing a strain on local resources. Increased efficiency in the emergency department through use of telemedicine should improve access to primary care which should result in better management of heart disease and its complications.

**Relationship to other Projects:**

1.7.1 –“Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region”, provides a basis for more efficient assessments and more initiation of care. It is closely related to the Category 4 project “Improves Quality”. It provides better coordination with primary care physicians to provide better management of chronic conditions. In rural communities there is a close relation between primary care and the emergency department. Many of the physicians who staff the emergency department also work in the community as primary care physicians. Coordination of care is necessary to better manage chronic conditions.

2.2- Expansion of the chronic care management model seeks to reduce unnecessary acute and emergency room utilization by of easy access to primary care. Primary care can better manage chronic conditions such as hypertension, obesity and diabetes. Timely screenings identify conditions at an early stage that permit better management and leads to a more efficient use of resources.

2.3 - Redesign Primary Care – Expansion of the chronic care management model above
places more demands on PCP’s and their clinics to provide easy access. Timely screening for early detection of chronic conditions requires efficient scheduling. Expansion of primary care capacity increases the likelihood of this outcome.

2.4 - “Redesign to improve Patient Experience” depends upon easy access to primary care. A major frustration is the long wait time for appointments, up to 6 weeks. Expanding primary care capacity reduces wait times, making it easier for patients to remember appointments. “No shows” decrease the patient experience.

1.10 – “Enhance Performance Improvement and Reporting Capacity”. Performance improvement processes will be integrated to the expansion of primary care capacity and the category 3 outcomes of screenings for diabetic patients. Since these activities are major component to clinic efficiency, education will be provided to physicians and their staffs.

**Relationship to Other Performing Providers’ Projects in the RHP:**

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**Plan for Learning Collaborative:**

University Health System in San Antonio as the anchor hospital for RHP 6 is promoting and organizing learning collaborative. Frio Regional Hospital will participate with those hospitals performing similarly related projects to network and share best practices and solutions.

**Project Valuation:**

Out of all potential DSRIP projects considered, Frio Regional Hospital has chosen DSRIP Project 1.7.1, “Introduce, Expand, or Enhance Telemedicine/Telehealth”. This project received a score of 5 on a scale of 1-5 in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment.

This project will affect all citizens of Frio County. It will have a positive impact on neighboring communities especially San Antonio, in that appropriate care delivered locally will reduce the need for transfers to that community. It will allow patients to seek care locally and avoid the complications resulting from unmanaged chronic conditions. Frio Regional Hospital is the main provider of acute and emergent care in Frio County. These efficiencies will positively impact Frio Regional Hospital along with the rest of our community.
<table>
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<tr>
<th>112688002.1.2 PASS 2</th>
<th>1.7.1</th>
<th>1.7.1 (A)(B)</th>
<th>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</th>
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<tr>
<td>Frio Regional Hospital</td>
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<td>TPI - 112688002</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>112688002.3.4</td>
<td>3.IT-3.2</td>
<td>Congestive Heart Failure 30 day readmission rate</td>
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<td></td>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**

[P1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine

**Metric 1 [P-1.1.]:** Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.

**Baseline:** 0, No telemedicine program or services currently exist.

**Goal:** Submission of completed needs assessment

**Data Source:** Needs assessment

**Milestone 1:** Estimated Incentive Payment: $89,000

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**Milestone 2**

[P-6]: Implement or expand medical education and specialized training programs via telehealth program.

**Metric 1 [P-6.1.]:** Submission and number of distinct curriculums delivered

**Baseline:** 0, No medical education is currently be provided via telehealth.

**Goal:** Submission of documentation for all offered curriculums

**Data Source:** Program materials

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**Milestone 3**

[1-12.]: Increase number of telemedicine visits for each specialty identified as high need

**Metric 1 [I-12.1]:** number of telemedicine visits

**Numerator:** Number of visits in which patients are seen using telemedicine services for each type of medical or surgical subspecialty provided by specified timeframe (e.g. one year) and geographic area in a RHP or for individual provider.

**Denominator:** Number of patients referred to medical specialties

**Baseline:** Dys 3 telemedicine visits

**Goal:** 100 total telemedicine visits in Dys 4 across all specialties

**Data Source:** EHR or electronic

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**Milestone 4**

[1-12.]: Increase number of telemedicine visits for each specialty identified as high need

**Metric 1 [I-12.1]:** number of telemedicine visits

**Numerator:** Number of visits in which patients are seen using telemedicine services for each type of medical or surgical subspecialty provided by specified timeframe (e.g. one year) and geographic area in a RHP or for individual provider.

**Denominator:** Number of patients referred to medical specialties

**Baseline:** Dys 3 telemedicine visits

**Goal:** 200 total telemedicine visits in Dys across all specialties

**Data Source:** EHR or electronic
referral processing system; encounter records from telemedicine program  
   a. Rationale: Demonstrate increase in access due to teleservices  

Milestone 3: Estimated Incentive Payment: $100,000  

referral processing system; encounter records from telemedicine program  
   a. Rationale: Demonstrate increase in access due to teleservices  

Milestone 4 Estimated Incentive Payment: $110,000  

<table>
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<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $89,000</th>
<th>Year 3 Estimated Milestone Bundle Amount: $100,000</th>
<th>Year 4 Estimated Milestone Bundle Amount: $100,000</th>
<th>Year 5 Estimated Milestone Bundle Amount: $110,000</th>
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</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $399,000
### Identifying Project and Provider Information:

| Title: 1.1.2 Expand Existing Primary Care Capacity - GRMC |
| Unique RHP ID#: 138411709.1.1 – PASS 1 |
| Performing Provider: Guadalupe Regional Medical Center |
| Performing Provider TPI: 138411709 |

### Project Summary:

**Provider Description:** GRMC is a 125 bed city/county community hospital serving a population of approximately 100,000 in 8 counties.

**Intervention(s):** This project initially moves a long standing indigent clinic to the hospital campus, improving access and security. Short and long term goals are to increase the volume and scope of services to improve continuity, access and effectiveness of chronic disease care in the community.

**Need for the project:** The current clinic was in an unsafe and difficult to access building with no security, and is open for very limited hours during the month. Funding was based exclusively on charitable donations and volunteer time. The availability of clinics willing to accept chronic disease patients for free in Guadalupe County and surrounding communities does not exist.

**Target population:** The target population are indigent and uninsured patients with chronic disease such as diabetes, hypertension, CHF and COPD. We expect 100% of these patients to meet the financial qualifications of indigent or Medicaid. Eventually the clinic may grow to provide services for other chronic disease patients who do not have primary care support.

**Category 1 or 2 expected patient benefits:** The project seeks to increase patient volume by 100% in year three (80 patients per month) 150+% (120 patients per month) in year four and 200+% more (200 patients per month) in year five.

**Category 3 outcomes:** Our goal is to proactively manage uninsured patients with chronic disease, with a specific focus on diabetes. The hospital’s Prescription Assistance Program, which receives no federal funding, will be the primary resource used to ensure that patients receive necessary medications. The clinic will also provide regular free lab checks, ongoing education, and continuity of care. All these actions are intended to improve health and reduce unnecessary hospital admissions.

### Project Description:

**Project description:** A long standing, loosely organized group called the Christian Free Clinic is at risk of closing due to the current building’s unsafe condition and lack of medical resources. Local indigent and uninsured patients with chronic diseases who seek medical care at this clinic four evenings a month would have no medical options other than the ER. As a result of this need, and need to expand healthcare access to residents of Guadalupe County and its contiguous communities, GRMC will be providing space to this clinic, as well as augmenting its current structure with staff and resources to expand care to patients who are underserved and without insurance.

**Challenges identified:** The existing clinic building is in poor condition (i.e., no wheelchair access) limited personnel support, limited hours and medical resources, and no access to lab or imaging reports. Additionally, there is no well formalized process in place to track patients,
which makes it difficult to follow up with patients.

Project goal(s):
- Expand primary care access to indigent and uninsured population by relocating clinic to the hospital campus.
- Expand clinic hours of operation from one evening a week to three days a week.
- Add additional staff to clinic to provide for extended hours. Staff would include: one physician extender, one medical assistant/receptionist and one front office receptionist.
- Prevent unnecessary ER visits and hospital readmissions for uninsured diabetic population, who have been identified through the Christian Free Clinic, recently discharged from the hospital or local primary care clinics that do not have the time or means to support diabetic management and education for their patients.
- Prevent the number of diabetic-related hospital visits by providing diabetic education, access to free diabetic medications through the hospital’s prescription assistance program (for the uninsured or indigent population) and access to physician medical management for this chronic disease.

This project not only aims to address access to care, but provides access to medication to help those manage chronic illnesses. This project will also provide one-on-one education, free lab screenings to monitor A1C levels, and provide a system for follow-up care for patients with diabetes.

Ongoing quality initiatives this project will help to address:
- Avoidable hospital readmissions
- Medication education and management
- Transitional care resource for uninsured patients
- Improve ER patient flow & wait times
- Assist with patient follow up and compliance of medications and lab work, specifically for the diabetic population.

This project relates to the following RHP 6 Regional Goals:
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways. This project will support this goal by connecting patients to the necessary healthcare resources and/or services for free or at a substantially reduced cost.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties. This project will help meet this goal by expanding clinic access and healthcare resources to patients in the hospital’s eight-county service area who are identified as underserved and without insurance. Patients with Medicaid would fall into the financial classification to receive care.
- Improve outcomes while containing cost growth. This project will seek to impact this goal by connecting patients to necessary medications to manage their chronic illness, helping to avoid ER visits and potential inpatient hospital visits.

5-year expected outcome – This project aims to improve primary care access and outcomes of the uninsured and indigent population with identified chronic illnesses, specifically, those individuals diagnosed with diabetes. By expanding clinic hours to provide for day-time and evening healthcare access, it is expected that unnecessary emergency room visits will be reduced, readmission rates for diabetic related illnesses will be reduced and the less fortunate in
the community will have a dedicated resource to receive care and access to medications to help them manage their chronic illness.

**Starting Point/Baseline:**

Project Baseline: The clinic is currently seeing 6-10 patients per week, most who are being treated for one or more chronic illnesses. The hospital’s Prescription Assistance Program (PAP), which is a not for profit entity that receives no federal funding, provides uninsured and indigent patients with prescription medications for $15 a month. A large portion of patients who receive medication through the PAP have received care at the Christian Free Clinic. There are currently 84 Christian Free Clinic patients who are receiving medications through the PAP.

Once the clinic has been relocated, and staff levels and hours of operation have increased from one evening a week to three days a week with extended evening hours, we project patient volume to increase by 100% over baseline in year three, 150+% over baseline in year four, and 200+% over baseline in year five, based on the patient volume from the prior year’s reporting period.

**Rationale:**

1.1.2 Expand existing primary care capacity

Required core components:
- a) Expand primary care clinic space
- b) Expand primary care clinic hours
- c) Expand primary care clinic staff

Project core components will be addressed as follows:

We selected Project Option 1.1.2, Expand Existing Primary Care Capacity, after discovering the poor facility condition of Seguin’s Christian Free Clinic. The Clinic is in extreme need of safer access and increased square footage to provide primary care services to local uninsured and indigent patients. GRMC selected this project as a means to extend supportive resources to the clinic and voluntary providers who currently treat clinic patients one evening each week. GRMC views this clinic relocation as an opportunity to build on the Christian Free Clinic’s structure and augment the clinic with additional clinical staff support to provide the ability to expand clinic hours and care for underprivileged patients who cannot afford healthcare. The clinic expansion will be specifically carried forth with the addition of a physician extender, medical assistant and front office receptionist. One of the primary goals of this clinic is diabetic disease management and prevention, given that the majority of the patients currently being treated at the Christian Free Clinic are diagnosed with diabetes. Currently, 84 patients who receive care at the Christian Free Clinic are receiving medications from the Prescription Assistance Program (PAP) at the hospital.

The PAP, which is a department of the hospital, is supported by various local donors, as well as the hospital. Neither the PAP, nor any services related to the clinic project receives any federal funding.

The unique community needs identified the project addresses are: CN 2 & CN3. This project will address access to primary care for the uninsured and focus on chronic disease management of
diabetes.

GRMC would take this clinic on as a new project initiative, as there is no community clinic owned or supported by the hospital at this time to enhance access to primary care services to the uninsured, nor is there a local community clinic willing to see patients for free except for the Christian Free Clinic. GRMC would build on the Christian Free Clinic’s structure, which is a non-profit tax exempt organization, and offer expanded services by means of hours, staff, and educational resources. The Christian Free Clinic in its current location and weekly operating schedule sees on average 6-10 patients a week, approximately 40 patients a month.

The prevalence of Type II Diabetes in Guadalupe County is currently 11.7%, compared to the national rate of 8.3%. It is currently an unmanaged issue in Seguin and surrounding communities, due to lack of patient access to medical care, affordability of diabetic medications, and lack of educational resources and follow-up support services.

Expanding clinic hours will impact the greater community due to the fact there is not a clinic open and available during normal business hours (8-5pm) that is willing to accept patients free of charge. Currently, diabetic patients end up in the emergency room, and are often times costly admissions because they cannot acquire or afford their diabetic medications. By focusing on the diabetic population in this clinic, we expect to see a reduction in unnecessary ER visits, reduction in diabetic related hospital admissions and readmissions, and a greater rate of diabetes management/compliance given the access to free healthcare resources.

**Related Category 3 Outcome Measure(s):**

We selected Improvement Target (IT)-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (stand-alone measure) from Category 3, due to the high prevalence of patients diagnosed with diabetes in the Seguin and surrounding communities; and, because it is one of the leading causes of death in our region, as noted in our community needs assessment.

The goal of this clinic is not only to expand access to care for those who are uninsured, but to proactively manage those patients who have been diagnosed with diabetes. Clinic staff will ensure that patients receive their prescribed medications by means of the hospital’s Prescription Assistance Program, receive free regular lab checks, and on-going education for their illness, by arranging follow-up appointments to the clinic.

Our Category 1 project will impact the target of this outcome, as well as impact the greater community due to the fact there is not a clinic resource open and available at normal business times. Currently, these patients end up in the emergency room, and are often times costly admissions because they cannot acquire or afford their diabetic medications.

**Relationship to other Projects:**

This project will support GRMC’s Transitional Care Project, RHP 2.12, and Patient Navigation Project, RHP 2.9 by providing a valued clinic resource for follow up care for those patients identified without insurance and a primary care physician. The collaboration of these two projects will help ensure these patients receive follow up care once out of the hospital or Emergency Room.

By focusing on the diabetic population in this clinic, we expect to see a reduction in unnecessary ER visits, reduction in diabetic related hospital admissions and readmissions, and a greater rate of diabetes management compliance given the access to free healthcare resources.
In addition, RHP Projects: 2.2, 2.7, 2.9, 2.11 will also be impacted by the addition of this clinic because of its focus and slated resources on chronic disease management of diabetes and prevention.

Related projects include:
- 2.2 Expand Chronic Care Models
- 2.7 Implement Evidence-based Disease Prevention Programs
- 2.9 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
- 2.11 Conduct Medication Management
- 2.12 Implement/Expand Care Transitions Program

Category 4 population measure:
RD-1. Potentially Preventable Admissions, 2ii
#2 Diabetes Admission Rates
ii. Uncontrolled Diabetes (derived from AHRQ Prevention Quality Indicator (PQI) #14)
   a. Numerator: All inpatient discharges from all participating hospital age 18 and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year
   b. Denominator: Number of residents age 18 and older living in the RHP counties

Relationship to Other Performing Providers’ Projects in the RHP:
N/A

Plan for Learning Collaborative:
GRMC is interested in participating in a learning collaborative with other regional partners pursuing similar projects.

Project Valuation:
The scope of this project should be categorized as a large project, due to the amount of staff resources, supplies and systems that will be needed to develop, train, and manage a growing clinic. In response to our community needs assessment, we anticipate this clinic growing quickly with patients, given the lack of uninsured access to health care in our community. Currently, the Christian Free Clinic is funded by charitable donations from local organizations, however, the amount of money received monthly, which is approximately $3,000.00 is nowhere near the amount of funds needed to support monthly operations of a clinic.

The clinic will also be marketed to local primary care physicians as a valuable educational resource for indigent or uninsured patients with chronic diabetic needs. It is recognized that physicians have limited time to spend on one-on-one education with their patients. This clinic will help fill that void by being a referral source for diabetic education, in addition to managing other chronic illnesses.
**138411709.1.1**
PASS 1

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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
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### Guadalupe Regional Medical Center

#### TPI - 138411709

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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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**Milestone 1**
P-1: Establish additional/expand existing/relocate primary care clinics.  
**Metric 1 [P-1.1]:** Relocate clinic to larger space on hospital campus.  
**Baseline:** Current clinic space is approximately 1,000 square feet  
**Goal:** Relocate clinic to a larger more sustainable office space on the hospital campus with approximately 1,500 square feet.  
**Data Source:** Documentation of relocation of clinic address and notice to patients.  
**Milestone 1 Estimated Incentive Payment $ 549,022**

**Milestone 2**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1 (P-5.1):** Documentation of staff training and education.  
**Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider report, policy, contract or other documentation.  
**GRMC will use a service education log as its data source.**  
**Baseline:** There are currently no staff hired or trained to operate this clinic.  
**Goal:** Train medical assistant and front office receptionist staff specifically on diabetic patient tracking and management.  

**Milestone 3**
P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric (P-5.1):** Documentation of staff training and education.  
**Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider report, policy, contract or other documentation.  
**Baseline:** There are currently no staff hired or trained to operate this clinic.  
**Goal:** Train medical assistant and front office receptionist staff specifically on diabetic patient tracking and management.

**Milestone 4**
P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours  
**Metric (P-4.1):** Increase clinic hours from three days a week, to two extended evening hours per week a month.  
**Data Source:** Clinic documentation/Patient registry/office schedule  
**Baseline:** Office hours are three days a week 8-5pm  
**Goal:** Extend hours two days a week to 8pm  
**Milestone 4 Estimated Incentive Payment $600,694**

**Milestone 5**
P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours  
**Metric (P-4.1):** Increase clinic hours from three days a week, to two extended evening hours per week a month.  
**Data Source:** Clinic documentation/Patient registry/office schedule  
**Baseline:** Office hours are three days a week 8-5pm  
**Goal:** Extend hours two days a week to 8pm  
**Milestone 4 Estimated Incentive Payment $600,694**

**Milestone 6**
P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours  
**Metric (P-4.1):** Increase clinic hours from three days a week, to two extended evening hours per week a month.  
**Data Source:** Clinic documentation/Patient registry/office schedule  
**Baseline:** Office hours are three days a week 8-5pm  
**Goal:** Extend hours two days a week to 8pm  
**Milestone 4 Estimated Incentive Payment $600,694**

**Milestone 7**
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.  
**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  
**Data Source:** Patient registry/Clinic documentation/schedule  
**Baseline:** 120 visits per month  
**Goal:** Increase patient visits 200+% over baseline (240 visits per month)  
**Milestone 8 Estimated Incentive Payment $992,451**
**Metric:** (P-5.1): Documentation of increased number of providers and staff and/or clinic sites  
**Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider report, policy, contract or other documentation. GRMC will use a personnel log and/or in-service education log as its data source.  
**Baseline:** There are currently no employees hired to operate this clinic, only four volunteer physicians and one non-clinical volunteer.  
**Goal:** Hire & train a physician extender, medical assistant/ receptionist and front office receptionist.

Milestone 2 Estimated Incentive Payment: $549,021

**Milestone 3**  
**Incentive Payment:** $399,302

**Milestone 4**  
P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours  
**Metric:** (P-4.1.): Increase number of hours at primary clinic over baseline.  
**Data Source:** Clinic documentation  
**Baseline:** one evening per week.  
**Goal:** Clinic operating three days per week from 8-5pm  
**Milestone 4 Estimated Incentive Payment** $399,302

**Milestone 5**  
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1** [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  
**Data Source:** Patient registry  
**Baseline:**  
**Goal:** Increase the number of visits by 150+% over baseline (120 visit per month)  
**Milestone 7 Estimated Incentive Payment** $600,694
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<td>$992,451</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,489,788**
Identifying Project and Provider Information:

Title: 1.1.2 - Expand existing primary care capacity: a) expand primary care clinic space; b) expand primary care clinic hours; and c) expand primary care clinic staffing.
Unique RHP ID#: 133260309.1.1 – PASS 1
Performing Provider: Medina Healthcare System (Medina Regional Hospital)
Performing Provider TPI: 212140201

Project Summary:

Provider Description: Medina Healthcare System is comprised of Medina Regional Hospital (“MRH”) and three Rural Health Clinics. MRH is a 25 bed critical access hospital and is the sole hospital provider in Medina County with an approximate population of 47,000 and square mileage of 1,335. The hospital is located in the City of Hondo, which is a 10 square mile area, and approximate population of 9,000.

Intervention(s): This project will add needed staff (physicians and/or mid-level providers), clinic staff, and square footage to increase clinic visits and expand clinic hours. This project is therefore an expansion of our existing clinics.

Need for the project: As the only rural health clinics in the County, the facilities are overcrowded with almost 48,000 visits annually. Patients walk out due to long waits and cancel appointments. With very little weekend access, patients often seek medical attention through the busy and costly emergency department. These issues are due to inadequate access to primary care.

Target population: The target population is those patients in the County that need medical (primary) care access to physicians/mid-level providers (not only during 8-5 hours), but also after hours and on weekends. Approximately 32% of our clinic patients are Medicaid or indigent. Many more are by definition charity patients.

Category 1 or 2 expected patient benefits: This project seeks to expand clinic hours/staff and space available to improve access to care. By DY(4) and (5), the project seeks to increase clinic visits by 3% (1,435 patients) and 5% (2,390 patients) respectively. In addition, the unique number of patients will increase by 3% (450 patients) and 5% (750 patients) from the baseline number. Currently, primary care physicians have over 47,000 combined visits annually. Thirty-two percent of these patients are Medicaid or indigent.

Category 3 outcomes:
1. 3.IT-1.12 seeks to increase the percent of qualified patients who receive an eye exam (retinal or dilated) currently by (TBD) % by DY5.
2. 3.IT-1.13 seeks to increase diabetic foot exams in qualified patients by (TBD)% in DY5.
3. 3.IT-1.14 our goal is to increase the number of diabetic patients who had a nephropathy screening test by (TBD) % in DY5.
**Project Description:**

Medina Regional Hospital proposes to expand primary care capacity to improve accessibility to citizens of the County and surrounding areas.

DSRIP Project 133260309.1.1, “Expanding Primary Care Capacity” is essential to providing accessible healthcare to citizens of Medina County, Texas. Access to comprehensive, quality services is important for the achievement of health equity and for increasing the quality of life. This goal requires: gaining entry into the system, accessing a location where services are provided, and finding a trusted healthcare provider. The goal of “expanding capacity” would allow patients to access the right care in the right place at the right time. This goal will be accomplished by adding healthcare providers and increasing the hours of Medina Regional Hospital (MRH) health clinics, as well as some expansion of space. Achieving this goal would allow patients access to care outside normal business hours reducing trips to Bexar County or improper utilization of emergency departments. This utilization of “after hours” emergency sites results in less coordinated, as well as more costly care.

**Goals and Relationship to Regional Goals:**

The goal of this project is to expand primary care capacity in the region by seeking to keep patients healthier, and thereby lessening the burden of regional emergency departments. By increasing access, patients can utilize the appropriate care destination both in Medina County and in RHP6 in general.

**Project Goals:**

The project/option selected is: Expand Existing Primary Care Capacity with the corresponding components of:

a) Expand Primary Clinic Space;
b) Expand Primary Clinic Hours; and
c) Expand Primary Clinic Staffing

This project meets the following regional goals:

- Transform healthcare by providing the right care at the right location and in a timely manner, thereby reducing costly care, unnecessary hospitalization, and builds on the strength of the RHP.
- Develops a regional approach to healthcare delivery that improves existing programs in our hospital and the region.
  
  This goal is responsive to patient needs and should improve overall patient satisfaction.

**Challenges:**

As Medina County is a designated “health professional shortage area”, recruitment and retention of physicians and mid-levels (Physician Assistants and Nurse Practitioners) are major challenges in meeting the goal described above. Medina Healthcare System (MHS) plans to increase recruitment efforts and employ outside agencies to meet these challenges. A staffing plan will be implemented to ensure the extended hours of the clinic become a reality. Efficient scheduling remains an obstacle to care access predominantly due to the lack of an electronic medical record system and an outdated scheduling process. MRH has purchased an electronic system and plans are underway for a “go-live” date.
5-Year Expected outcome for Provider and Patients:
Medina Regional Hospital expects to see improvements in the number of visits and unique patients seeking care in our rural health clinics. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
In the fiscal year ending on September 30, 2012, the number of patient visits in rural health clinics of MHS, equaled 47,850. In September 2012, care was delivered utilizing one physician assistant, one nurse practitioner, 24 clinic staff members, and six Family Practice physicians. Three full-time schedulers were employed for all three clinics. Patient record keeping and scheduling utilize a slow, cumbersome process, and no electronic health record is in place.

Rationale:
Regional Health Partnership (RHP) 6 reports a high uninsured rate as well as reportable poor health outcomes. This RHP is composed of 54% Hispanic and 37% Anglo population. Spanish is the predominant language in many homes. 12% are 65 years of age or older; many with limited mobility/transportation issues. The per capita income is less than the state average. In 2009, 16% of the population lived below the poverty line. Medina County averaged 11%-20%. In 2009, 471,000 residents lacked health insurance, particularly in rural areas such as Medina County. Many residents are employed by small businesses or are self-employed. This lack of insurance is another barrier to access to “primary care” services. Thirty-three providers in RHP 6 are designated as Rural Health Clinics. Medina Regional Hospital is designated as a Critical Access Hospital and manages three rural health clinics located in Hondo, Castroville and Devine.

The National Rural Health Association (NRHA) has identified several issues of particular interest to rural communities, the first of which is “access to health care services, particularly health disparities and physician shortages.” Rural counties in RHP 6 comprise 61% of the geographical area. This highlights the importance of safety net providers and explains the importance of increasing access to primary care, both in the RHP and in Medina County. The citizens in these counties tend to be older, less educated, with lower per capita income.

Continued population growth, both in the RHP and Medina County, will exacerbate the current challenge of providing primary care services. Future decisions (Medicaid expansion, health insurance, exchanges, etc.) could have a significant impact on the health status of residents in Medina County. This opportunity to implement the transformative project of increasing access to primary care (through the 1115 Waiver funding) will assist MRH in addressing the needs of its community.

In Medina County, patients often seek care for primary care services in urgent or emergent care settings. This can result in a less coordinated and more expensive approach to healthcare. Lack of appropriate follow-up is yet another downside to this type of care. When primary care clinics are closed (after-hours, weekends, holidays) or scheduling is difficult, residents seek treatment in the emergency department, or worse, seek no treatment at all. Particularly with the elderly and indigent populations, transportation to other counties (such as Bexar County) is not a viable option. Conditions can exacerbate during these time periods leading to an increase in possibly preventable readmissions. This can also be complicated by the inability to receive appointments.
in a timely manner.
By enhancing clinic hours, expanding appointment times, and generally improving access to

care, patients should align themselves with the primary care system in Medina County resulting

in better outcomes, improved coordination of care, and reduced costs.

The prevalence of other chronic diseases, such as diabetes, cancer and cardiovascular disease, is

above state and national levels. 60% of the deaths in 2008 in RHP 6 were due to these potentially

preventable causes. Access to providers, extended hours and more efficient scheduling could
certainly assist in preventing these deaths. The rural health clinics service over 47,000 visits,

with patients from birth to death. Access to a primary care provider is essential to this county

and for patients of all ages.

According to the 2011 physician needs assessment, Medina County was short six Family

Practice physicians. According to the County Health Rankings and Roadmaps, Medina County
showed 1,701 residents per Family Practice practitioner. This is well below the national
benchmark of 631:1. Texas ranks 45th in the nation in number of physicians per capita. The
Region’s growing population, increased life spans and growing prevalence of chronic diseases,
contribute to an accelerated need for primary care providers. For children, access to primary
care is extremely important. The FY 2010 Texas Medicaid Managed Care STAR Program
Quality of Care Report stated that less than 80% of children between the ages of three to five had
a well-child visit. Adult obesity was 30% compared to the national average of 25% and diabetic
screening was 79% compared to 89%.

Low birth weight was 7.9% compared to 6% nationally, and the teen birth rate was 55 (compared
to 22).

The project chosen certainly addresses the RHP and the county needs. To fulfill that project,
process and outcome measures were chosen that specifically lead us to the desired outcomes.

The process milestones selected were:

1. P-4 – Expand the hours of a primary care clinic, including evening and/or weekend hours, and
   P-4.1 will be the metric increasing hours over the baseline. The current hours for the rural
   health clinics as of FYE 9/30/12 are: 9am-5pm (Monday-Friday); Saturday (Hondo) 9am-
   11am.

2. P-5 – Train, hire additional primary care providers and staff as evidenced by P-5.1
   Documentation of increased numbers of providers and staff in Devine, Hondo and/or
   Castroville.

The improvement target selected is I-12 with the milestone being the increase in clinic visits as
evidenced by improved access.

I-12.1 – Will be the documentation of increased visits
I-12.2 – Documentation of the number of unique patients or size of patient panels
Clinic space will also be enhanced/expanded to meet the growing volume of patients.

One specific chronic disease target will be diabetes. The diabetes rate in Bexar County is 10%
and more than double for African Americans and Hispanics (13%) as compared to Whites (6%). The population of Texas will continue to grow and a portion of this growth (18%) will be from international migration from Mexico. According to national examination services, Hispanics are almost twice as likely as non-Hispanic Whites to develop diabetes.

According to the Agency on Healthcare Research, Texas scored “weak” on preventative measures and “weak” on diabetes measures. In fact, in RHP 6, diabetes was listed as one of the top causes of death. Disease management, screening and wellness programs are crucial to reducing morbidity and mortality due to diabetes. By improving access to care and allowing for increased visits, thereby increasing screening exams, diabetes can be better managed in Medina County. Many diabetic complications can be prevented if detected and addressed early. Control of diabetes can extend and improve the quality of lives of thousands of patients in Medina County.

**Project Components:**
To expand primary care access we propose to meet all required project components.

a) Expand primary care clinic space. We plan to increase existing space to allow for the increase in patient volume. An expansion plan will be developed addressing space priorities.

b) Expand primary care capacity hours. We plan to increase hours by offering services on weekends and later in the evening. This should allow patients more flexibility in scheduling as well as “drop-in” hours. Extended hours should also lower the hospital ED utilization.

c) Expand primary care capacity staffing. We plan to hire an additional provider (mid-level, physician or both) as well as clinic staff to improve throughput, scheduling, and patient satisfaction.

**Unique community need identification numbers the project addresses:**
Screening is obviously an important factor in improving health outcomes of both RHP 6 and in Medina County. A summary of RHP 6 needs includes one most relevant to Medina County and that is:

- CN.3- Many residents lack access to medical and dental care due to high rates of uninsured and healthcare provider shortages. As a provider with almost 50,000 visits annually, increasing access to primary care will enhance our existing primary care delivery processes.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project significantly enhances the care currently being delivered. When the clinics are closed, patients seek care mainly in the only emergency room in the county, or make the long trip into Bexar County, or seek no care at all.

All these circumstances lead to increased costs and fractionated care in both the County and RHP 6. Increasing access to providers, expanding the hours/space of the clinics, will certainly lead to better healthcare for children, adults, and the elderly in Medina County.
### Related Category 3 Outcome Measure(s):

**Related Category 3 Outcome Measures**

Three non-stand-alone measures were chosen from Category 3 to include:

**Outcome Domain – 1 (Primary Care and Chronic Disease Management)**
- IT-1.12 Diabetes Care: Retinal Eye Exam
- IT-1.13 Diabetes Foot Care Exam
- IT-1.14 Diabetic Care: Microalbumin/Neuropathy

**Reasons/rationale for selecting the outcome measures:**
These were chosen because diabetes is one of the most common and costly diseases in both RHP 6 and in Medina County. Half of all residents with diabetes go undiagnosed, making screening a vital part of primary care in the area. Complications cost millions of dollars and undiagnosed diabetes can lead to amputations, blindness, and kidney failure. In the *County Health Rankings and Roadmaps*, Medina County scores below both Texas and national benchmarks in diabetic screening. Adult obesity ranks high at 30%, as well as a 26% score on physical activity.

Given the high prevalence of diabetes in the RHP and the County, fueled by a high obesity rate, access to fast foods, a high rate of uninsured/underinsured, low educational levels and the percentage of residents living below the poverty line (16%), screening for complications and prevalence of diabetes is of vital importance to the healthcare needs of Medina County.

The rural health clinics in Medina County, with over 47,000 visits annually, serve the primary healthcare needs of many of these residents. Improving access to primary care will provide even more citizens the screening exam needed to live a healthier lifestyle, and at a reduced cost.

**Note:** Medina Regional Hospital purchased an EHR system in 2012 and plans to go-live in 2013, but this is not directly related to this project.

### Relationship to other Projects:

1.1.2 – Expanding primary care capacity is interrelated to numerous other 1115 Waiver Projects in several categories.

2.2 - Expanding the chronic care management model aims to reduce unnecessary acute and emergency care utilization by effectively managing chronic conditions (i.e. diabetes). Elements include the ability to identify these conditions earlier. Expanding primary care access and diagnosing diabetes earlier, go hand-in-hand.

2.3 – Redesign Primary Care – As patient volumes increase, physicians struggle to ensure their patients have prompt access to care and receive adequate screenings for chronic conditions. Receiving appointments timely and understanding service availability, is the rationale for this project option which indirectly in line with 1.1.2 expanding primary care capacity. Increasing providers and hours certainly leads to improved primary care 2.3.

2.4 – Redesign to improve Patient Experience is also closely related to 1.1.2. Improved access to
care and more flexible scheduling can only result in an improved patient care experience. With an improved experience, patients should “keep appointments” and can be followed more closely.

1.1.2 (Increase training of Primary Care Workforce) is obviously related to expanding primary care capacity. Expanding the primary care workforce will increase capacity and help create a more organized structure of providers and space. The expansion will lead to earlier diagnosis and treatment of chronic diseases and decrease healthcare costs overall. In 2010, Texas ranked 47 in numbers of primary care physicians per 100,000 in population. Improving this number is key to expanding capacity.

1.3 – Implement a Chronic Disease Management Registry. Although not a direct link, the ability to track screening results of patients with diabetes by improving primary care access has the similar goal of “prompting” physicians and teams to conduct assessments and deliver specific recommended cure. For example, P-8 would create protocols for reminders for targeted diseases (such as screening exams for diabetes).

1.10 – Enhance Performance Improvement and Reporting Capacity. Performance improvement activities will be woven into expanding primary care capacity and Category 3 outcomes of screenings for diabetic patient conditions. “Performance improvement is a large component of success of all of the project areas across the categories.” Education and training will be provided to physicians and staff in process improvement strategies.

### Relationship to Other Performing Providers’ Projects in the RHP:

Other performers selecting this project include:

Methodist Hospital System
Frio Regional Hospital
Southwest General Hospital
Guadalupe Regional Medical Center
University Hospital
University of Texas Health Science Center (San Antonio)
Peterson Regional Medical Center
Baptist Medical Center
Val Verde Regional Medical Center
Children’s Hospital of San Antonio

Many of these facilities are geographically positioned with overlapping patients. Improving access will assist all these patients and simultaneously reduce ED visits.

### Plan for Learning Collaborative:

As the anchor for RHP 6, University Health System will promote and facilitate learning collaboratives. Medina Regional Hospital will participate with many of the above providers performing similar projects to share ideas, best practices, challenges and success stories. Working groups will be formed to establish the goals, develop a calendar for meetings, and share ideas. New solutions can be tested.
**Project Valuation:**

This project touches almost all citizens in Medina County, and in fact, compliments other providers in the RHP. By improving access to care, costly preventable admissions and over-utilization of emergency departments will be decreased in Medina as well as neighboring counties such as Bexar and Uvalde. Cost avoidance is obviously a major justification for this project. Barriers to accessing health services lead to delays in receiving appropriate care, inability to receive preventative services, and hospitalizations that could have been prevented. In terms of cost, providers including physicians, mid-levels and staff will need to be hired and trained. Processes will have to be developed and implemented. As the only hospital in Medina County, access to care is both beneficial and a priority. Over 47,000 visits to the clinics were recorded last year. As the demand for healthcare increases (through migration, population growth, baby boomer aging), demand will rise even farther.
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<td>3.IT-1.13</td>
<td>Diabetes Care: Foot Exam</td>
</tr>
<tr>
<td>Outcome</td>
<td>133260309.3.3</td>
<td>3.IT-1.14</td>
<td>Diabetes Care: Microalbumin/Nephropathy</td>
</tr>
<tr>
<td>Measure(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 1</td>
<td></td>
<td>Milestone 2</td>
<td>Milestone 3</td>
</tr>
<tr>
<td>[P5]: Train/hire additional primary care providers and staff.</td>
<td>[P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours.</td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
</tr>
<tr>
<td>Metric 1</td>
<td></td>
<td>Metric 1</td>
<td>Metric 1</td>
</tr>
<tr>
<td>[P-5.1]:</td>
<td></td>
<td>[P-4.1]:</td>
<td>[I-12.1]:</td>
</tr>
<tr>
<td>Documentation of increased number of providers and staff.</td>
<td>Increased number of primary care clinic hours over baseline.</td>
<td>Documentation of increased number of visits.</td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal:</td>
<td></td>
<td>Baseline:</td>
<td>Baseline:</td>
</tr>
<tr>
<td>Baseline: Six physicians, 2 mid-levels, 3 full-time plus 1 PRN scheduler, ½ FTE Administration, 24 full-time staff.</td>
<td>Baseline: Current hours: 9-5 weekdays; Saturday (Hondo only) 9am-11am.</td>
<td>DY1 number of clinic visits (47,838).</td>
<td></td>
</tr>
<tr>
<td>Goal: Add one additional physician or mid-level; add one scheduler, hire full-time Administrator, increase staff.</td>
<td>Goal: Extended hours on weekends (8 hours monthly), weekday evenings (8 hours monthly).</td>
<td>Goal: Increase volume of visits by 3% from DRY1 totals.</td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td></td>
<td>Data Source:</td>
<td>Data Source:</td>
</tr>
<tr>
<td>Staffing plan, physician contract</td>
<td>Posted hours/clinic documentation.</td>
<td>EHR</td>
<td>EHR</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $586,795</td>
<td></td>
<td>Milestone 2 Estimated Incentive Payment: $680,172</td>
<td></td>
</tr>
<tr>
<td>Milestone 2</td>
<td></td>
<td>Milestone 3</td>
<td>Milestone 4</td>
</tr>
<tr>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
</tr>
<tr>
<td>Metric 2</td>
<td></td>
<td>Metric 2</td>
<td>Metric 2</td>
</tr>
<tr>
<td>[I-12.2]:</td>
<td></td>
<td>[I-12.2]:</td>
<td>[I-12.2]:</td>
</tr>
<tr>
<td>Documentation of increased number of unique patients or size of patient panels.</td>
<td>Documentation of increased number of unique patients or size of patient panels.</td>
<td>Documentation of increased number of unique patients or size of patient panels.</td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal:</td>
<td></td>
<td>Baseline:</td>
<td>Baseline:</td>
</tr>
<tr>
<td>Goal: Increase by 5% from DY1 number.</td>
<td>Goal: Increase by 5% from DY1 number.</td>
<td>Goal: Increase by 5% from DY1 number.</td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td></td>
<td>Data Source:</td>
<td>Data Source:</td>
</tr>
<tr>
<td>EHR</td>
<td></td>
<td>EHR</td>
<td>EHR</td>
</tr>
</tbody>
</table>
3% from DY1 volumes.  
Data Source: EHR  
Milestone 3 Estimated Incentive Payment: $687,202  

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $586,795</th>
<th>Year 3 Estimated Milestone Bundle Amount: $680,172</th>
<th>Year 4 Estimated Milestone Bundle Amount: $687,202</th>
<th>Year 5 Estimated Milestone Bundle Amount: $588,779</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,542,948**
Identifying Project and Provider Information:
Title: 1.10.1 Enhance improvement capacity within people – Medina Healthcare System
Unique RHP ID#: 133260309.1.2 – PASS 2
Performing Provider: Medina Healthcare System (Medina Regional Hospital)
Performing Provider TPI: 212140201

Project Summary:
Provider Description: Medina Healthcare System is comprised of Medina Regional Hospital (“MRH”) and three Rural Health Clinics. MRH is a 25 bed critical access hospital and is the sole hospital provider in Medina County with an approximate population of 47,000 and square mileage of 1,335. The hospital is located in the City of Hondo, which is a 10 square mile area, and approximate population of 9,000.

Intervention(s): This project will lead to the implementation of process improvement methodologies that will improve patient safety, quality, and efficiency. Resources will be put in place to conduct, report, drive and measure quality improvement; Specifically an office and director will be established/hired and a formal process of education will be implemented.

Need for the project: Currently, the hospital has no director or office for Process Improvement or Quality. No formal methodology is being utilized and little data reporting is taking place, which complicates the ability to improve upon patient safety initiatives or report mandated/meaningful data. Although it is an expansion of our current process, this project will be a huge undertaking for this facility.

Target population: The target population is those patients served in our rural health clinics and hospital. Approximately 32% of our clinic patients are Medicaid or indigent, and will benefit from this project. Many more by definition are considered charity patients. The hospital inpatient/outpatient percent of Medicaid/indigent approximates 20%.

Category 1 or 2 expected patient benefits: The project seeks to increase the number of reports generated to three in DY4 and to submit three quality dashboards by DY5. Additionally, we seek to increase the number of performance activities (designed and implemented) to three in DY4 and demonstrate improvement in two selected quality measures by DY5. We will also utilize this Category 1 project to drive improvements in three Category 3 areas.

All employees (approximately 200) will be affected and educated during this project. Additionally, the primary care physicians will be educated and benefited by this project. With advanced process improvement training, over 47,000 clinic patients will benefit as well as 1100 inpatient hospital patients (Approximately 32% of clinic patients are Medicaid or indigent.).

Category 3 outcomes:
1. 3.IT-12.1 seeks to increase the number of women aged 40-69 that have received an annual mammogram by (TBD) % in DY4 and (TBD) % over baseline in DY5.

2. 3.IT-12.2 seeks to increase the number of women aged 21-64 that have received a PAP measurement (in the measurement year or two prior years) by (TBD) % over baseline in DY4 and (TBD) % over baseline in DY5.
3. 3.IT-12.4 seeks to increase the number of adults aged 65 and older that have received a pneumonia vaccine by (TBD) % in DY4 and (TBD) % over baseline in DY5.

<table>
<thead>
<tr>
<th>Project Description:</th>
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</thead>
<tbody>
<tr>
<td>Medina Regional Hospital proposes 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.</td>
</tr>
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</table>

DSRIP Project 212140201.1.10, “Enhance Performance Improvement and Reporting Capacity” will lead to the implementation of process improvement methodologies that will improve patient safety, quality and efficiency. A new operational mindset will be instituted to lead staff to identify inefficiencies in the healthcare delivery system and to work toward the elimination of these inefficiencies.

Process improvement in healthcare is imperative in today’s rapidly changing environment. These improvements assure that our systems are operating at their optimum. The goals of healthcare process improvement are to enhance the effectiveness of systems to alleviate waste/cost and ultimately improve the quality of the patient experience, care and outcomes. Improvement in numerous areas will allow us to reduce duplication of efforts and minimize the waste of resources. Changing the management of critical processes can generate a 20-50% improvement in those processes impacting patient and employee satisfaction, as well as the bottom line. With the IOM’s “to err is human” and “crossing the quality chasm”, a widespread incidence of medical errors in U.S. hospitals was reported. The IOM report estimated that medication errors alone caused more than 7,000 deaths annually. Additionally, “to err is human” revealed that between 44,000 and 98,000 Americans die each year due to medical errors, and total costs of these errors are estimated to be between $17 billion and $29 billion dollars, with healthcare costs comprising over 50%. According to Health Aff. (2006), in 2003, Medicare paid hospitals an additional $300 million per year for five types of adverse events. Healthcare professionals also pay with a loss of morale and increased turnover.

Since then, much progress has been made in developing indicators and risk adjustment mechanisms to compare and improve quality across systems. Hospitals that perform well on process measures have better outcomes, employee and patient satisfaction, and reduced costs.

**Goals and Relationship to Regional Goals:**
The goal of this project is 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 Goals:**
The project/option selected is: Enhance Performance Improvement and Reporting Capacity with the corresponding components of:

<p>| |</p>
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<tr>
<td>d) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture; and</td>
</tr>
<tr>
<td>e) Develop an employee suggestion system that allows for the identification of issues that</td>
</tr>
</tbody>
</table>
impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

This project meets the following regional goals:

- One of the key goals of the Waiver and RHP6 is to improve and prepare the healthcare infrastructure’s newly insured population. This will require effective management, enhanced technology and improved processes to promote quality care and to reduce the costs. RHP6 represents a vast area with many rural communities where poor health outcomes are common. Limited access to primary and specialty care exacerbates these problems. Healthcare facilities in RHP6 must become efficient in delivering care to an increasing population. The region has a high emergency room utilization, low access to primary/specialty care, and 125,090 potentially preventable hospitalizations leading to charges of $1,700 per adult living in the region’s counties. Performance improvement is key to improvement in all the categories named above, plus all the other projects in the partnership. It meets the triple aim of assuring patients receive high quality and patient centered care, in the most cost effective ways.

- This project will assist in developing a regional approach to healthcare delivery that enhances or replaces an existing process in our hospital system and RHP. The goal is responsive to patient needs and should improve overall patient satisfaction.

Challenges:
The primary challenge for this project will be the recruitment and retention of a qualified process improvement coordinator to engage the stakeholders. As a health provider shortage area, recruiting a well-trained, passionate Director to lead process improvement will be difficult. Obtaining management and staff buy-in to a formal change process may also prove to be daunting, as well as rolling out process methodologies throughout the medical and hospital staff.

5-Year Expected outcome for Provider and Patients:
Medina Regional Hospital expects to have a Performance Improvement office with a qualified director leading the change for a formalized quality performance program. Our goal is to have a substantial workforce that is trained and using various performance improvement tools in approaching work and cost efficiencies while reducing variations in processes.

Starting Point/Baseline:
Currently no position for Director of Process Improvement/Quality exists at Medina Regional Hospital. No formal methodology is being utilized at this time and little date reporting/charting is taking place. Therefore, the baseline number of employees in the process improvement department is zero, and dedicated space is also zero.
**Rationale:**

Enhancing performance improvement and reporting capacity will lead to the implementation of process improvement methodologies that will improve patient safety, quality and efficiency. A new operational mindset will be instituted to lead staff to identify inefficiencies in the healthcare delivery system and to work toward the elimination of these inefficiencies.

The project chosen certainly addresses the RHP and the county needs. To fulfill that project, process and outcome measures were chosen that specifically lead us to the desired outcomes. The process milestones selected were:

1. **P-1** – Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system.
   - **P-1.1** Metric documentation of the establishment of performance improvement office.
   - **P-1.2** Documentation that the performance improvement office is engaged in collecting, analyzing, and managing real-time data.

2. **P-2** – Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program should be required to lead an improvement project in their department within six months of completing their training.
   - **P-2.1** Train-the-trainer program established.
   - **P-2.2** Improvement projects led by staff trained through the train-the-trainer program.

3. **P-9** - Participation in face-to-face learning/meetings/seminars at least twice a year with other providers and the RHP to promote collaborative learning around similar and shared projects.
   - **P-9.1** Participate in semi-annual meetings or seminars

The improvement targets selected are:

**I-7** Milestone: Implement quality improvement data systems, collection, and reporting capabilities.
- **I-7.1** Metric: Increase the number of reports generated through these quality improvement data systems.
- **I-7.2** Metric: Demonstrate how quality reports are used to drive rapid-cycle performance improvement.

**I-8** Milestone: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures.
- **I-8.1** Metric: Submission of quality dashboard or scorecard.

**I-9** Milestone: Demonstrated improvement in x number of selected quality measures.
- **I-9.1** Metric: Improvement in selected quality measures.
**Project Components:**
To enhance improvement capacity within people we propose to meet all the required components.

d) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture.
e) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction efficiency and other issues aligned with continuous process improvement.
f) Continuous quality improvement is reflected in Milestone 4 [I-7], Metrics I-7.1 and I-7.2 (implementing quality improvement data systems, collection, and reporting capabilities). CQI is also reflected in [I-7.2] utilizing quality reports to drive rapid cycle performance improvement. Additionally, Milestone 6 [I-9] projects demonstrated improvement in two selected quality measures.

**Unique community need identification numbers the project addresses:**
Performance improvement is obviously an important factor in improving health outcomes of both RHP 6 and in Medina County. A summary of RHP 6 needs includes three which are most relevant to Medina County and they are:

- CN.1- Texas ranks last in the nation on health care quality. RHP6 is challenged to deliver improved quality and patient satisfaction.
- CN.2- A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients.
- CN.6-High rates of communicable diseases and vaccine preventable diseases in the community.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently a formal process or methodology for process improvement is not being utilized. This formalized methodology, led by a qualified Quality Director, represents a significant enhancement to the evaluation of resources. Process improvement permeates every aspect of each initiative in RHP6.

**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Outcome Domain – 12 (Primary Care and Primary Prevention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-12.1 Breast Cancer Screening</td>
</tr>
<tr>
<td>• Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.</td>
</tr>
<tr>
<td>IT-12.2 Cervical Cancer Screening</td>
</tr>
</tbody>
</table>
Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

IT-12.4 Pneumonia Vaccination Status for Older Adults
- Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine.
- Denominator: Number of adults aged 64 and older in the patient or target population.

Reasons/rationale for selecting the outcome measures:
These were chosen because primary screening as well as preventative vaccinations contribute to early detection and prevention, increasing health outcomes of individuals.

Mammography screening (52%) in Medina County is well below the national benchmark of 74%. According to the Agency for Healthcare Research and Quality’s 2011 Report, Texas scored WEAK in preventative measures and AVERAGE on cancer measures. Cancer is a leading cause of death in RHP6. Medina Regional Hospital will utilize the Category 1 project (Process Improvement) to improve both mammography and cervical cancer screening, as well as pneumonia vaccinations in Medina County.

Education and training on process improvement measures to front line staff, directors, clinical and non-clinical staff, and the establishment of the employee suggestion process, will position Medina Regional Hospital to evaluate current plans and discharge tools to improve preventive measures such as our I-T targets.

Relationship to other Projects:
This project is a direct link to 1.1.2, “Expanding Primary Care Staffing”. Process improvement is needed to enhance recruitment/retention efforts. Additionally, an enhanced process improvement methodology will be needed to improve efficiencies in the clinics to improve patient flow and all projects to improve efficiencies and reduce waste will be integrated to this project. This project supports the 1115 Waiver and Triple Aim Goals to improve outcomes while containing cost growth. The tools selected will focus on reducing undesirable variations, which will support Medina Regional Hospital’s and RHP 6 goals.

Relationship to Other Performing Providers’ Projects in the RHP:
The Baptist Health System and University Health Science Center have also selected “expanding quality improvement capacity” as DSRIP projects. This will facilitate learning collaboratives with other providers in RHP6. Selection Pros/Cons of methodologies can be discussed as well as best practices.

Plan for Learning Collaborative:
As the anchor for RHP 6, University Health System will promote and facilitate learning collaboratives. Medina Regional Hospital will participate with many of the above providers performing similar projects to share ideas, best practices, challenges and success stories. Working groups will be formed to establish the goals, develop a calendar for meetings, and share ideas. New solutions can be tested.
<table>
<thead>
<tr>
<th><strong>Project Valuation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This project touches all aspects of the hospital’s delivery systems. Cost avoidance is a major component of this valuation due to the fact that by improving systems and increasing efficiencies, outcomes can be affected: reduction in mortality, reduction in medical errors, reduction in medication errors, etc. With a formalized department, reporting/benchmarking and process improvements should lead to a happier and healthier community. The project therefore adds much strength to the hospital through: 1) cost avoidance; 2) improvement in patient satisfaction; and 3) hospital efficiencies. As the demand for healthcare increases (through migration, population growth, aging baby boomers, etc.), demand will use even further, necessitating the need for more efficiencies and a streamlined resource allocation process.</td>
</tr>
</tbody>
</table>

The implementation of a formal process improvement methodology will assist in addressing a substantial need in the community for increased efficiency, and improvement in the quality of care.
<table>
<thead>
<tr>
<th>133260309.1.2 PASS 2</th>
<th>1.10.1</th>
<th>1.10.1 (A)(B)</th>
<th>1.10.1 Enhance improvement capacity within people – Medina Healthcare System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>133260309.3.4</td>
<td>3.IT-12.1</td>
<td>Primary Care and Primary Prevention: Breast Cancer Screening</td>
</tr>
<tr>
<td>Outcome</td>
<td>133260309.3.5</td>
<td>3.IT-12.2</td>
<td>Primary Care and Primary Prevention: Cervical Cancer Screening</td>
</tr>
<tr>
<td>Measure(s):</td>
<td>133260309.3.6</td>
<td>3.IT-12.4</td>
<td>Primary Care and Primary Prevention: Pneumonia Vaccination</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Status for Older Adults</td>
</tr>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td>[P1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across Medina Regional Hospital’s delivery system.</td>
<td><strong>Milestone 2</strong></td>
<td>[P2]: Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program will be required to lead an improvement project in their department within six months of completing their training.</td>
</tr>
<tr>
<td>Metric 1 [P-1.1]:</td>
<td>Documentation of the establishment of performance improvement office, including director position.</td>
<td>Metric 1 [P-2.1]: Train the trainer program established.</td>
<td>Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems:</td>
</tr>
<tr>
<td>Baseline:</td>
<td>No office currently, no approved position.</td>
<td>Baseline: Zero number of staff trained.</td>
<td>a. Numerator: Number of reports generated.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>HR documents, office policies/procedures.</td>
<td>Data Source: HR, training program materials (including documentation of the number of hours of training required).</td>
<td>Goal: Three Reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Source: Quality improvement data systems.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Metric 2 [I-7.2]: Demonstrate how quality reports are used to</td>
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</tbody>
</table>

Milestone 5 Estimated Incentive Payment: $78,702
<table>
<thead>
<tr>
<th>Metric 2 [P-1.2]: Documentation that the performance improvement office is engaged in collecting, analyzing, and managing real-time data.</th>
</tr>
</thead>
</table>
| Baseline: Zero formal reports.  
Goal: Three monthly dashboards.  
Data Source: Dashboards |
| Milestone 1 Estimated Incentive Payment: $156,271 |

<table>
<thead>
<tr>
<th>Metric 2 [P-2.2]: Improvement projects led by staff trained through the train the trainer program, within six months of completion of training.</th>
</tr>
</thead>
</table>
| Baseline: Zero improvement projects.  
Goal: One improvement project per trainer = 5 projects led.  
Data Source: Documentation of improvement projects. |
| Milestone 2 Estimated Incentive Payment: $90,708 |

<table>
<thead>
<tr>
<th>Milestone 3 [P9]: Participation in face-to-face learning (meetings/seminars) at least twice/year with other providers and the RHP to promote collaborative learning around shared and similar projects. At each meeting, we will identify and agree upon several improvements.</th>
</tr>
</thead>
</table>
| Metric 1 [P-9.1]: Participate in semi-annual face-to-face drive rapid-cycle performance improvement:  
a. Number of performance activities that were designed and implemented based on data in the reports |
| Milestone 4 Estimated Incentive Payment: $183,941 |

<table>
<thead>
<tr>
<th>Milestone 6 [I-9]: Demonstrated improvement in two selected quality measures.</th>
</tr>
</thead>
</table>
| Metric 1 [I-9.1]: Improvement in selected quality measures.  
Baseline: Zero Quality Measures  
Goal: Two quality measures showing improvement.  
Data Source: Quality improvement data systems. |
| Milestone 6 Estimated Incentive Payment: $78,703 |
meetings or seminars organized by the RHP.

Baseline: Zero meetings currently.
Goal: Two meetings per year.
Data Source: Meeting agendas.

Milestone 3 Estimated Incentive Payment: $90,708

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Milestone Bundle Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>$156,271</td>
</tr>
<tr>
<td>Year 3</td>
<td>$181,416</td>
</tr>
<tr>
<td>Year 4</td>
<td>$183,941</td>
</tr>
<tr>
<td>Year 5</td>
<td>$157,405</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $679,033**
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>1.7.1 Introduce, Expand, or Enhance Telemedicine/Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>094154402.1.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Methodist Hospital</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>094154402</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider Description:** Methodist Hospital, 45-0388, includes the campuses of six acute care hospitals: Methodist Hospital, Methodist Children’s Hospital, Methodist Specialty and Transplant Hospital, Northeast Methodist Hospital, Metropolitan Methodist Hospital, and Methodist Texan Hospital. For more than 49 years Methodist has provided high quality care to patients from San Antonio and throughout South Texas.

**Intervention(s):** Methodist Hospital will deploy telehealth services that will provide instant Telehealth consultations with trained specialists in selected services affiliated with Methodist Hospital. This will allow patients experiencing barriers to specialty care to receive initial care in their home facility. The specialist will evaluate the patient via Telehealth consultation and decide which interventions will benefit the patient. This will allow all members of the healthcare team to monitor the patient’s status, treatment plan, and disease management.

**Need for the project:** The goal of this program is to bring the best of acute diagnosis and treatment recommendations to remote communities, which often do not have specialists and the resources to provide the advanced medical treatments. Approximately 18% of patients in rural community hospitals are transferred to San Antonio for specialty care that could be handled by rural hospitals with availability to specialists.

**Target population:** Target populations are patients that present to Emergency Departments at facilities without specialty physician coverage. Approximately 30% of patients are either Medicaid and/or indigent patients and are expected to benefit from this project.

**Category 1 or 2 expected patient benefits:** This project will increase Telehealth visits to 150 by DY5. This process will significantly increase the quality of care to the patients by having the specialist see and communicate with the patient in order to best assess their ability for local care or the need to start therapy and transport to a regional facility. Approximately 50 telemedicine visits are estimated during the baseline period in DY 3. MHS has estimated that the telemedicine visits will be 100 for DY 4 and 150 for DY 5. Methodist Hospital estimates that approximately 30% of these patient are indigent and Medicaid patients.

**Category 3 outcomes:** Improve patient satisfaction by 2% in DY4 and 4% in DY5. Percentage increases are in line with the community estimated access rate.

### Project Description:

Methodist Healthcare System will operate a telemedicine network to enhance care for patients in a San Antonio, Texas and surrounding area. We expect call to consultation times to decrease and quality of care, due to a virtual consultation, to increase. This program will also align clinical protocols between facilities to enhance care of patients. Developing a telemedicine network has proved difficult in the past due to significant costs, both with equipment and with physician specialty coverage. Additionally, only recently has the technology improved enough that it is
now reasonable to expect it to be able to provide consistent and reliable connection and the ability for a specialist to have a clinical interaction with a patient.

This telemedicine network will allow facilities to network with our hospital system for specialty coverage that is lacking or non-existent. This has the potential to provide significant benefit to families and patients.

The five year outcome is expected to increase patient access to specialists in order to improve patient health.

This project is aligned with the following Region 6 goals:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Improve outcomes while containing cost growth

No other federal funds will be utilized for the funding of this project.

**Starting Point/Baseline:**

This project will be assessed to determine most appropriate community need in DY2. Once assessed, the Telemedicine program will be implemented in DY3. The baseline will be determined in year of implementation. The baseline will be telemedicine visits compared to total visits.

**Rationale:**

There is currently a shortage of specialists and subspecialists in nearly every community. Subspecialists are in very short supply in Bexar and the surrounding counties as well. This project brings a specialist to the patient’s bedside when needed. Patients will be better served by a virtual consultation in which the specialist is able to see and speak to the patient, the family, and the attending doctor and make timely decisions on treatment and transfer. This program should allow more patients to stay in their local facility while facilitating the transfer and treatment of high acuity patients to a facility with a higher level of care.

**Core Project Components:**

e. Provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications.

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

This project address the Community Needs Assessment for these items:

CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver
improved quality and patient satisfaction.
CN.2 - A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.
CN.3 - Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-9 Right Care, Right Setting – RHP Outcome ID 094154402.3.1</td>
</tr>
<tr>
<td>Category 3 Outcome Measure IT-9.4</td>
</tr>
<tr>
<td>Improved access to health care services for residents of communities that did not have such services locally before the program.</td>
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<tr>
<td>Methodist Healthcare System will measure if the patient’s access to care was improved over baseline visits. The baseline will be determined in DY3. Subsequent years will attempt to improve access to care by the end of waiver.</td>
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</table>

<table>
<thead>
<tr>
<th>Relationship to other Projects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The telemedicine project will support MHS Project 094154402.1.2- Expand Specialty Care Capacity- Freestanding ED. Telemedicine will be available for consults in the ED where specialty coverage is not available.</td>
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<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
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<tbody>
<tr>
<td>Unknown at this time.</td>
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<tr>
<th>Plan for Learning Collaborative:</th>
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<tbody>
<tr>
<td>Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.</td>
</tr>
<tr>
<td>The telemedicine program’s results and processes will be shared with all participating facilities. Additionally, protocols will be aligned between facilities and our San Antonio hospitals. Feedback on processes, treatments, and metrics will be shared with all partnering facilities.</td>
</tr>
</tbody>
</table>
**Project Valuation:**

Methodist’s project valuation used a method which ranked the importance of each project based on several key factors. First, Methodist considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Methodist considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Methodist reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project; the investment of the performing provider, and the overall value to the community, to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

In valuing the project, Methodist took into account the extent to which a telemedicine program would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project. The telemedicine project is projected to go live in DY 3. This will provide significant benefit in avoiding unnecessary medical transportation costs, family hardship, and enhancing the remote facilities ability to care for patients locally. Additionally, with the live consultation of a specialist, we will be able to administer therapy appropriately and arrange for a higher level of care when necessary.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>094154402.3.1</th>
<th>3.IT 6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
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<tr>
<td>[P-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine</td>
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<tr>
<td><strong>Metric 1</strong> [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.</td>
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<tr>
<td><strong>Baseline/Goal:</strong> Determine area telemedicine has greatest community need.</td>
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<tr>
<td><strong>Data Source:</strong> Needs assessment</td>
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $2,367,434</td>
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<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
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<tr>
<td><strong>Milestone 2</strong></td>
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<tr>
<td>[P-3]: Implement telemedicine program for selected medical specialties, based upon regional and community need.</td>
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<tr>
<td><strong>Metric 1</strong> [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.</td>
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<tr>
<td><strong>Goal:</strong> Implement telemedicine program and establish a baseline. Estimate 50 visits</td>
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<tr>
<td><strong>Data Source:</strong> Program materials</td>
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<tr>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $1,291,371</td>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<td><strong>Milestone 4</strong></td>
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<tr>
<td>[I-12]: Increase number of telemedicine visits for each specialty identified as high need.</td>
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<tr>
<td><strong>Metric 1:</strong> I-12.1. Number of telemedicine visits</td>
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<td><strong>Goal:</strong> Increase telemedicine visits to 100/year.</td>
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<tr>
<td><strong>Data Source:</strong> EHR or electronic referral processing system; encounter records from telemedicine program</td>
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<tr>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $2,590,251</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 5</strong></td>
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<tr>
<td>[I-12]: Increase number of telemedicine visits for each specialty identified as high need.</td>
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<tr>
<td><strong>Metric 1:</strong> I-12.1. Number of telemedicine visits</td>
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<tr>
<td><strong>Goal:</strong> Increase telemedicine visits to 150/year.</td>
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<tr>
<td><strong>Data Source:</strong> EHR or electronic referral processing system; encounter records from telemedicine program</td>
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<tr>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $2,139,773</td>
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</table>
**Milestone 3**

[P-4.1]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.

**Metric 1:** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.

**Goal:** Implement telemedicine program to targeted health services based on community need.

**Data Source:** Program materials

**Milestone 3 Estimated Incentive Payment:** $1,291,372

| Year 2 Estimated Milestone Bundle Amount: $2,367,434 | Year 3 Estimated Milestone Bundle Amount: $2,582,743 | Year 4 Estimated Milestone Bundle Amount: $2,590,251 | Year 5 Estimated Milestone Bundle Amount: $2,139,773 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,680,200**
Identifying Project and Provider Information:

Title: 1.9.2 Improve access to specialty care
Unique RHP ID#: 094154402.1.2 - PASS 1
Performing Provider: Methodist Hospital
Performing Provider TPI: 094154402

Project Summary:

Provider Description: Methodist Hospital, 45-0388, includes the campuses of six acute care hospitals: Methodist Hospital, Methodist Children’s Hospital, Methodist Specialty and Transplant Hospital, Northeast Methodist Hospital, Metropolitan Methodist Hospital, and Methodist Texan Hospital. For more than 49 years Methodist has provided high quality care to patients from San Antonio and throughout South Texas.

Intervention(s): Project is to expand specialty care capacity by locating a Freestanding ED in Westside of San Antonio in a community area of need. Because of the population size of Bexar County (1.8 million) and the CBSA (2.5 million) and this projected growth, just about every geographic area of San Antonio is currently and will continue to be underserved by primary care providers and emergency health care services. There is a void of emergent health care services related to continuing and significant population growth, as well as ongoing traffic difficulties from the Westside into the South Texas Medical Center. Through 2016 the high risk population growth (65+) will top 39.9% versus Bexar County’s overall growth in this age cohort of 24.9%. Furthermore, San Antonio’s Westside population in every age cohort is growing faster than any other area of San Antonio. It is because of this growth, especially in the high risk age cohorts, that there is consideration for the development of a freestanding emergency center to be located in a high traffic area, and with easy access to all parts of the Westside.

Need for the project: San Antonio is experiencing the largest population growth in virtually every geographic area when compared to Texas and other US cities of similar size. Emergency care services that mimic the same type of emergent services found in a hospital is vitally important to these high growth areas because of current need, future growth and travel difficulties. When looking a population growth projections for 2013 - 2018, the Northeast side will grow by 9% (Texas will grow by 7.9% and Bexar County will grow by 8.5%), Northwest: 10.8%, North Central: 10.5%, Downtown: 4.2%. Even in the slower growing southern geographic areas (Southeast and Southwest San Antonio), the population growth will just about match the overall growth of Bexar County. Furthermore, the high risk health population (65+) will grow by double digits in every area of San Antonio. In the San Antonio MSA the current population is 2.17 million and is expected to grow to over 2.56 million by 2021 (18%).

Target population: The target population is our patients that need emergency services in areas demonstrating community need. Approximately 26% of patients are either Medicaid and/or indigent patients, and are expected to benefit from this project. These patients will be served equally as any other patient presenting to this emergency center.

Category 1 or 2 expected patient benefits: The project seeks to provide increase emergency room visits in an area of community need by 2,053 visits in DY 3, 4,721 visits in DY 4, and 5,132 visits in DY5.

Category 3 outcomes: 3.IT-6.1 - Our goal is to increase number of patient surveys by 4% by
DY % and reach top 50th percentage of patient satisfaction.

**Project Description:**

Project is to expand specialty care capacity by locating a Freestanding ED in Westside of San Antonio. San Antonio is experiencing significant population growth in almost every geographic sector. Because of the population size of Bexar County (1.8 million) and the MSA (2.17 million) and this projected growth, just about every geographic area of San Antonio is currently and will continue to be underserved by primary care providers and emergency health care services. Furthermore, the delays in travel to local providers in the Medical Center (where the bulk of healthcare services are delivered to this population) are more pronounced because of our current population and the continued growth that will be experienced over time. On the Westside of San Antonio there is a void of emergent health care services related to continuing and significant population growth, as well as ongoing traffic difficulties from the Westside into the South Texas Medical Center. Through 2016 the high risk population growth (65+) will top 39.9% versus Bexar County’s overall growth in this age cohort of 24.9%. Furthermore, San Antonio’s Westside population in every age cohort is growing faster than any other area of San Antonio. It is because of this growth, especially in the high risk age cohorts, that there is consideration for the development of a freestanding emergency center to be located in a high traffic area, and with easy access to all parts of the Westside.

One challenge that Methodist Hospital will be facing is the shortage of physicians. According to the AMA, Texas has a significant shortage of physicians and with Medicare and Medicaid reimbursement cuts; physicians are more likely not to service those types of patients. There is also the challenge of recruiting nurses with a Texas nursing shortage. With state funding cuts for nursing education, the shortage for nurses are at 22,000 full-time nurses, and this amount expected to increase to 70,000 by 2020. Another challenge and goal is to help these patients get engaged in their own healthcare to ensure a good outcome.

While these challenges may seem daunting, Methodist has a very aggressive physician recruitment program that addresses these recruitment challenges. For instance, in 2012 Methodist credentialed 424 new physicians and recruited from outside of San Antonio an additional 38 physicians to the market. The same can be said about the current Methodist nurse recruitment program. In 2012, Methodist hired 893 additional nurses, and employs a fulltime nurse recruitment staff to assist in this activity. Methodist also has a long history of wellness and prevention activities targeted to the community at large, as well as area employers. A significant number of our community benefit activities are directed toward assisting participants in understanding and continually engaging in improving personal health. As an example, in 2012 Methodist offered 2,621 complimentary communities wellness and prevention events, with a high percentage of these activities targeting those most disenfranchised in our community.

Core project components:

A freestanding emergency facility located on the Westside of San Antonio will be open 24/7/365
and staffed with appropriate clinicians, including board certified emergency physicians. Referrals into this center will be mostly walk-in, as the center will be easy to access because of its location at a major high traffic crossroad in the area. This project will mimic a typical emergency center found in any acute care hospital, and will implement the same clinical and quality treatment and improvement protocols as would be expected in any hospital setting. Furthermore, this center will be open to the entire population regardless of their ability to pay for services, as indicated by Mission of the Methodist Healthcare System - Serving Humanity to Honor God.

Methodist understands that continuous quality improvement is at the heart of this project. Therefore, in the implementation of this project, Methodist will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, Methodist will ensure that all methodologies used will meet or exceed any applicable nationally recognized protocol or quality benchmarks.

The target population is our patients that need emergency services in areas demonstrating community need. Approximately 26% of patients are either Medicaid and/or indigent patients, and are expected to benefit from this project. These patients will be served equally as any other patient presenting to this emergency center.

This project is aligned with the following Region 6 goals (Triple Aim):

- Assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system

Starting Point/Baseline:
Baseline will be determined in DY3 for ED visits.

Rationale:
San Antonio is experiencing the largest population growth in virtually every geographic area when compared to Texas and other US cities of similar size. Emergency care services that mimic the same type of emergent services found in a hospital are vitally important to these high growth areas because of current need and future growth. Convenience, quality of care, quicker service, and a full compliment of emergent care diagnostics are the goals and metrics of this project. Furthermore, third-party research indicates just about every geographic area in San Antonio is currently underserved for this type of service, and will continue to be if new emergency care services are not developed (the continued growth of ER visits from every part of San Antonio and to every hospital is witness to the need to increase ED and primary care infrastructure capacity - but closer to the neighborhoods and in a less costly construction
environment).

Project components included in the Freestanding ED:

   a) Increase service availability with extended hours – operating hours are 24 hours/365 days a year

   b) Increase number of specialty clinic locations- increase clinic location in Westside of San Antonio

   c) Implement transparent, standardized referrals across the system - MHS will promote the location, services and hours of operation throughout the service area (consumers and physicians) to increase referrals (walk-ins) to the center.

   d) Conduct quality improvement for project - This project will mimic a typical emergency center found in any acute care hospital, and will implement the same clinical and quality treatment and improvement protocols as would be expected in any hospital setting.

This project address the Community Needs Assessment for these items:

CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

CN.3 - Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>IT-6.1 Patient Satisfaction – Unique RHP Outcome ID: 094154402.3.2</th>
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</table>

Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

**Relationship to other Projects:**

The Expand Specialty Care Capacity- Freestanding ED will support MHS Project 094154402.1.1- Introduce, Expand, or Enhance Telemedicine/Telehealth. Telemedicine can be made available for consults in the ED where specialty coverage is not available.
**Relationship to Other Performing Providers’ Projects in the RHP:**
Baptist Health Services and CHRISTUS Santa Rosa have begun expanding services in the Westside of San Antonio.

**Plan for Learning Collaborative:**
Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

**Project Valuation:**
Methodist’s project valuation used a method which ranked the importance of each project based on several key factors. First, Methodist considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Methodist considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Methodist reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project; the investment of the performing provider, and the overall value to the community, to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The freestanding emergency room will significantly improve access to the highest quality emergency medical treatment to patients that live in areas not geographically located close to an existing acute care hospital, or challenged by increasing traffic issues. This directly addresses the goals by improving the coordinated care delivery system and will address a community need by providing access to emergency services closer to the homes of patients that do not currently have an acute care hospital near their home. Methodist took these factors into account when determining the incentive value of this project.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>094154402.3.2</th>
<th>3.1T-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
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<tbody>
<tr>
<td><strong>Year 2</strong> <em>(10/1/2012 – 9/30/2013)</em></td>
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<tr>
<td><strong>Milestone 1</strong> [P-1]: Conduct specialty care gap assessment based on community need.</td>
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<tr>
<td><strong>Metric 1</strong> [P-1.1] Documentation of gap assessment.</td>
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<tr>
<td>Baseline/Goal: Identify gaps in high-demand specialty. <em>Identify areas of need for Freestanding ED.</em></td>
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<tr>
<td>Data Source: Needs Assessment</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $2,564,720</td>
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<td><strong>Year 3</strong> <em>(10/1/2013 – 9/30/2014)</em></td>
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<td><strong>Milestone 2</strong> [P-11]: Launch/expand a specialty care clinic – Freestanding ED.</td>
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<tr>
<td><strong>Metric 1</strong> [P-11.1] Establish/expand specialty care clinics- Freestanding ED.</td>
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<tr>
<td>Baseline/Goal: Improve access for targeted populations in areas where there are gaps in healthcare services. <em>Establish baseline for visits and patient satisfaction. Estimated baseline is 2,053 visits (projected opened 6 months in DY3).</em></td>
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<tr>
<td>Data Source: Hospital ED information</td>
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<tr>
<td>Milestone 2 Estimated Incentive Payment: $2,797,971</td>
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<tr>
<td><strong>Milestone 3</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
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<tr>
<td><strong>Metric 1</strong> [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY3).</td>
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<tr>
<td>Goal: <em>Increase ER visits in area of community need to 4,721 visits (annually).</em></td>
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<td>Data Source: Hospital ED information</td>
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<td>Milestone 3 Estimated Incentive Payment: $2,806,105</td>
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<td><strong>Year 5</strong> <em>(10/1/2015 – 9/30/2016)</em></td>
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<tr>
<td><strong>Milestone 4</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
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<tr>
<td><strong>Metric 1</strong> [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY3).</td>
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<tr>
<td>Goal: <em>Increase ER visits in area of community need 5,132 visits (annually).</em></td>
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<td>Data Source: Hospital ED information</td>
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<td>Year</td>
<td>Estimated Milestone Bundle Amount</td>
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<td>Year 2</td>
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<td>$2,318,087</td>
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<td>Year 4</td>
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<td>Year 5</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $10,486,883
### Identifying Project Information:

| Project Name: 1.10.2 Enhance Improvement Capacity through Technology |
|-----------------|----------------------------------------------------------|
| Unique RHP ID#: 127294003.1.1 – PASS 2 |
| Provider Name: Peterson Regional Medical Center (PRMC) |
| TPI: 127294003 |

### Project Summary:

**Provider Description:** Peterson Regional Medical Center (PRMC) is the only healthcare organization within Kerr County and is located in the town of Kerrville. The population for Kerrville (2011) was listed as 22,423 and the population for Kerr County (2011) was 49,783. Kerr County is a total of 1,108 sq miles (45 persons/sq mile) with only 20.3 (1,100.7 persons/sq mile) of that belonging to Kerrville. PRMC provides healthcare and medical resources to nine surrounding counties with a total population of 187,293. Kerr County has been listed as a Healthcare Provider shortage area; this however is magnified by the fact that the majority of surrounding counties is also listed as shortage areas, and/or is unable to provide any healthcare services at all. It was found in our Community Health Needs Assessment held in October of this year that 28% of Kerr County’s population is unfunded, which is much higher than the national average of unfunded population which was found to be 16% and the national benchmark 11%. The cost of care for these groups is on the rise; it is crucial that changing our practice to provide efficient, cost effective, high quality care is placed at the top of our priority list. Of PRMC’s total diabetic population visits, Medicaid/Indigent/Self-pay comprised 11%.

**Intervention(s):** This project will allow PRMC to arrange a decision support analyst position to write reports from our current data repository as well as manage software modules. The decision support analyst will utilize tools, technology, and applications to access clinical, financial, and quality information on a timely basis. The development of an enterprise data repository makes information available to support the hospitals strategic planning, process improvement management, and decision-making activities. This program will allow healthcare providers to acquire knowledge based on real time data from dashboards created permitting them to actively participate in the assessment of healthcare quality at our organization. PRMC plans to use this data being collected and reported to key organizational leaders to assess our current processes and implement new and improved process improvement teams. Evidence-based models will be used implementing these process improvement projects such as Lean, Six Sigma, or Malcolm Baldrige.

**Need for the project:** Studies by the National Institutes of Standards and Technology have found that organizations adopting quality management practices experience an overall improvement in employee relations, higher productivity, greater customer satisfaction, increased market share, and improved profitability. Current organizational leaders are uneducated on the use of data collected and reported, this program will allow for key leaders to be educated and trained on uses of data to improve the care we provide to our patients. This project is also needed to assist us in obtaining the information and data collection we need for our Pass 1 project that we are currently unable to retract from our repository. Rates of diabetes are in our community are increasing rapidly; future organizational operations will be unable to withstand the pressure of treating the flood of obesity-related diseases, newly insured population, and other financial tribulations at this rate. Consequently, while we search for better and more efficient ways of treating diabetes and helping people manage the disease in the outpatient setting so that costly procedures can be prevented, we must find more ways to education people during their hospitalization to make healthy lifestyle choices after they are discharge using parts of the data we plan to collect in our process improvement efforts. The high cost of diabetes complications- their long term effect on the...
individuals quality of life, the high treatment costs, the fact that they are largely preventable, and the possibility for a sizable return on investment are all reason we feel this project is important to our organization and our community.

**Target population:** The target population that will be focused on is our community’s diabetic and un/under-funded populations. Kerr County went from being ranked 196th (out of 254 Texas Counties) in 2011 to 246th in 2012 in the diabetes category. If that alone wasn’t ample enough of a reason to target this population in our community, the reality of how many of our community residents are unfunded/underfunded compounds the complexity of being able to care for these patients with any kind of magnitude or degree of quality value extremely difficult.

**Category 1 or 2 expected patient benefits:** This project seeks to increase the number of reports generated through quality improvement data systems by producing the following reports for PRMC’s diabetic patient population: scheduled follow-up appointments post hospitalization, pharmacist coaching to patient/family prior to discharge, number of encounters with the Discharge Advocate, Emergency Room encounters, follow-up phone calls conducted post acute care discharge, scheduled outpatient diabetic education visits with diabetic educator and 30 day readmission rates. These reports will allow PRMC to focus on areas of needed improvement to drive improved quality of care and reduce healthcare cost within targeted diabetic population group in DY4. In DY5, a quality dashboard will be created and presented throughout the organization, demonstration to key leadership on the use of the dashboard to drive rapid-cycle performance improvement efforts.

**Category 3 outcomes:** OD-9 Right Care, Right Setting IT-9.2 Reduce Emergency Department visits for target condition-Diabetes will be executed in DY4 and DY5. 19% of total diabetic population visits at PRMC were seen in our ED in calendar year 2012. DY4 improvement target is to reduce ED visits as a percentage of total diabetic population visits by 5%. DY5 improvement target is to reduce ED visits as a percentage of total diabetic population visits by 5% for a total of 10%. To reach these goals actionable data will need to be obtained to verify PRMC’s Pass I project is operational. Currently PRMC does not have the resources or personnel to accomplish these data collection requirements.

**Project Description:**

**Peterson Regional Medical Center proposes to implement a process using technology to provide actionable data. Organization wide training on the use of that data to drive efficiency, improved quality measure monitoring, increase patient safety, and enhance patient-centered care activities throughout the entire system.**

Peterson Regional Medical Center (PRMC) currently lacks the availability of adequate data extraction and reporting skills to facilitate effective decision making for quality and safety improvement initiatives. This project will allow arrangement of a decision support analyst position to write reports from our current data repository as well as manage software modules. The decision support analyst will utilize tools, technology, and applications to access clinical, financial, and quality information on a timely basis. The development of an enterprise data repository makes information available to support the hospital's strategic planning, process improvement management, and decision-making activities.

Meaningful data can help to proactively address issues, measure progress and capitalize on quality improvement opportunities. It is essential that healthcare providers acquire the knowledge to actively participate in the assessment of healthcare quality. Decision support analysts assist departmental leaders in determining the information necessary to satisfy specific business and
customer demands. PRMC currently contracts with outside sources paying them to write customized reports and to develop data views and dashboards little and/or fragmented action takes place from the results reported due to a lack of education on how to use the information to make process improvements. Over the past year, PRMC has paid in excess of $50,000 to have reports developed. We have many other needs for additional development and education that we feel at this time we cannot afford to have done on a contract basis. Recruiting an experienced decision support analyst will allow PRMC to measure quantitative data against benchmarked standards in order to clarify and verify organizational focus on and progress towards PRMC’s strategic goals.

Studies by the National Institutes of Standards and Technology (NIST) have found organizations adopting quality management practices experience an overall improvement in employee relations, higher productivity, greater customer satisfaction, increased market share, and improved profitability. In combination with implementing a data support analyst, PRMC will adopt components of evidence based improvement methodologies such as Lean, Baldrige, and Six Sigma.

Once data collection efforts are available, specialized training to key organizational leaders will enhance our ability to effectively utilize info to make necessary system process improvements. Training will include evidence based process improvement methodologies such as Lean, Six Sigma, and Baldrige. Leaders will then demonstrate use of data and process improvement methodologies to positively impact outcomes. Outcomes to be impacted include: increased patient care quality and safety, health care cost reeducation, decreased waste, efficiency, and improvement of patient-centered activities. A system will be developed to allow employee input regarding potential or actual identified issues; and a dashboard program will be hardwired within our infrastructure providing real-time data accessibility to all employees throughout the organization.

Goals and Relationship to Regional Goals:
The goal of this project is to improve the organization’s ability to positively affect previously mentioned outcomes through better use of data and evidence based improvement methodologies. It is critical this project support not simply what is good for the company, but also what is good for its employees, stakeholders, suppliers, partners, collaborators, customers, and community as a whole.

Project Goals:
- Create strategic organizational goals that are focused and patient centered and to increase the availability of data to support data driven decision making
- Recruitment of an experienced decision support analyst
- Training for key organization leaders and employees on process improvement methods based on data collected
- Effective and timely use of data driven process improvement tools and activities
- Quality dashboard that allows information to be easily shared with organizational leadership at all levels
- Budgets, policies, practices and processes evaluated modified and improved based on valid data and evidence based improvement methodologies
- Reduce waste and variation in care processes to drive improvement in quality measures and patient care

Rates of diabetes are increasing throughout our community rapidly; future organizational
will not be able to withstand the pressure of treating the flood of obesity-related diseases. Consequently, while we search for better and more efficient ways of treating diabetes and helping people manage the disease in the outpatient setting so that costly procedures can be prevented, we must find more ways to educate people during their hospitalization to make healthy lifestyle choices after they are discharged using parts of the data we plan to collect in our process improvement efforts.

This project meets the following Regional Goals:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Improve outcomes while containing cost growth
- Further develop and maintain a coordinated care delivery system
- Improve and prepare the health care infrastructure to serve a newly insured population
- Health care information technology to improve communication and health care

Challenges:
Quantifying healthcare quality is complex and a challenging process, which exceeds PRMC’s current human resource capabilities. Currently, fragmentation of data flow occurs because of multiple collections of data silos. Other challenges PRMC faces are:

- Limited availability of timely data to guide improvement efforts
- Questionable validity of current data collection
- Duplicated data collection and improvement efforts across the organization
- Limited knowledge on effective use of data to prioritize measure and improve clinical, financial, and administrative processes
- Inability to devote current human resources to data collection and employee training efforts
- No current evidence based methodology process used effectively throughout the organization
- Information is not commonly shared with organizational leadership at all levels

We suspect that there are extensive gaps between the care that patients receive and what the medical community has determined to be the most effective care. Despite unrivaled technological innovation, it is difficult to ensure that all patient care being delivered meets the accepted standards of quality. Gaps in quality are responsible for wasteful, ineffective care, preventable medical complications, avoidable hospitalizations, decreased quality of life, disability, and premature death. As a result, there is a key need for better integration and sharing of data within and across our healthcare system and even within our entire community.

To address these challenges PRMC seeks to recruit an experienced decision support analysts and evidence based process improvement methodologies. Implementation of this project will provide leaders and frontline healthcare providers the resources to collecting and reporting health data which will help them to better characterize the nature of health or process problems in our organization and our community and develop actionable plans based on the findings. To ensure data is accurately and consistently collected and understood, PRMC will provide key leaders and employees from all levels throughout the organization, improvement methodology coaching.

5-Year Expected Outcome for Provider and Patients:
PRMC expects to see improvements in safety, quality of care, healthcare outcomes, and reduced healthcare cost based on reliable, timely, and actionable data collection findings.
Employees will be trained to use process improvement tools (ex: Lean, Six Sigma, PDSA or Rapid Cycle Improvement) teaching them how to read, evaluate and implement change or improvement based on the use of valid data collection mechanisms. A quality dashboard will be developed to disseminate information across levels within the organization. Standardizing specific components of data collection and using improvement methodology tools will create efficiency, drive patient centered care, narrow the focus of needs identified which results in improved quality, safety, and patient centered care leading to an overall healthcare cost reduction.

**Starting Point/Baseline:**

Currently PRMC data availability is fragmented with limited ability to extract, aggregate and disseminate data. Leadership and other staff members have little training in evidence-based processes such as Lean, Six Sigma or Rapid Cycle Improvement. A decision support analyst position does not exist at PRMC at this time. We currently utilize two outside resources, one for reports and the other to create dashboard views. In the past year, we have had a minimum of 40 reports written for our organization with costs exceeding $50,000. PRMCs baseline diabetic population in calendar year 2012 is a total of 3,719 patients with 12% or 1,226 visits having an inpatient stay.

**Rationale:**

Option 1.10.2 was chosen to correct current fragmented process improvement efforts and inefficient data collection systems. Excessive healthcare cost and errors can occur because of system and process failures. In an effort to improve operational effectiveness and create a culture of continuous improvement PRMC feels a combined approach of designing a reliable data collection process along with adopting process improvement techniques will address current inefficiencies, ineffective care, and preventable errors. Thus, allowing key process improvement personnel to influence quality improvements efforts and activities throughout the organization. When data is gathered, tracked, and analyzed in a more credible way, it becomes possible to measure progress and success or lack thereof. This project will assist in fostering a culture of change by developing an understanding of identified problems through data collection and caring out improvement opportunities by involving key stakeholders, testing change, and continuous evaluation to sustain change.

As mentioned before our target group that will be focused on first is our community’s diabetic population. The high cost of diabetes complications—their long term effect on individual quality of life, the high treatment costs, the fact that they are largely preventable, and the possibility for a sizable return on investment—provide inherent incentives for PRMC to assess the diabetes care in our organization and identify opportunities for quality improvement. Performance improvement and reporting capacity is a large component in determining the success of our Pass 1 project. The Pass 1 project has identified a need for data collection on our target population, which is not readily available today and would be expensive for us to acquire through contracted agencies. All data collection efforts and report writing is outsourced and is often returned in difficult to read formats or not including all data measurements requested within one single report. This makes it incredibly difficult in making anything from the report useful in process improvement efforts.

Both the NHQI and IOM’s *Crossing the Quality Chasm* report highlight the importance of improving care for chronic diseases. Diabetes in particular is recognized as one chronic disease for which quality improvement efforts could make great strides. Diabetes has widely respected national guidelines for what constitutes quality care and well-developed national measures of
quality. Despite this fact, the gap between evidence-based treatment and actual practice and outcomes continues to be wide. There continues to be a large number of complications from diabetes that research demonstrates could have been prevented with high quality care. We anticipate this resulting in better patient care and improved patient outcomes. This project option will provide the data collection mechanism to address the current cumbersome and complicated process of collecting baseline-starting points for the Pass 1 Option 2.12.1 project.

**Project Components:**

Through enhanced performance improvement and reporting capacity through technology, PRMC will meet the following required project components:

- **Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture** - Employment or expansion of an existing position will be evaluated to implement the role of a decision support analyst. The decision support analyst will collaborate with key stakeholders within our organization to review components of process improvement methods or tools such as PDSA, Six Sigma, and FMEA to be considered for use within our organization. Once these methods and tools for improvement have been chosen, in-depth education will be provided to key influential leaders from throughout the organization. These key players will then lead the way by allocating their efforts in educating the remainder of the workforce team.

- **Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement** – PRMC currently uses a mechanism similar for employees to use for such reporting called, Bright Idea. They are able to submit a Bright Idea from the Intranet home page, once it has been submitted it is sent to the Quality Improvement Department for review. This application is old and out dated; therefore, the process and application will be reviewed, updated, and improved as necessary to meet the need of our employees and the goals of this project.

- **Design data collection systems to collect real-time data that is used to drive continuous quality improvement.** A dashboard system will be developed allowing centralized accessibility to data collection systems. A central data repository will improve visibility of current data collection activity and reduce duplicated data collection efforts.

The unique community need identification numbers the project addresses:

CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction

CN.2 – A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes

How the project represents a new initiative or enhances an existing delivery system reform initiative:

A new initiative for implementing the position of a decision support analyst will be evaluated. This project will enhance and streamline current quality improvement efforts. This project will provide the capability to collect needed data in the Pass I initiative.

**Related Category 3 Outcome Measure(s):**

**OD-9 Right Care, Right Setting**
“The U.S. healthcare system wastes $700 billion annually on the kinds of systemic inefficiencies that would make a quality management guru cringe,” says Robert Kelly, Vice President of Healthcare Analytics at Thomson Reuters. This project will provide the ability to capture data needed for setting baseline measurements for our pass 1 project and other identified system failures in the future. Without validated reliable data and proven methodology, tools to learn how to turn data into valuable information our organization will remain stagnant. OD-9 Right Care, Right Setting and IT 9.2 (standalone) was chosen as the projects outcome domain based on 19% of overall diabetic population visits were Emergency Department setting. One goal of collecting meaningful data is to identify the frequency and cost of care of emergency department visits in PRMC’s diabetic population group. Once proper reports are generated we can identify trends which contributed to diabetic patients not seeking the right care in the right setting.

Because diabetes can result in expensive long-term complications, investing in diabetes control initiatives can improve health outcomes and reduce health care costs. Quality healthcare can be defined as the right care delivered in the right setting to the right person at the right time. Patients who do not understand the importance of the underlying premise that primary care will provide them with continuity and oversight of their overall health will look for the most convenient path to care, such as going to Emergency Rooms, and never realize the its consequences. Right care in the right setting offers continuity of care which improved treatment adherence, allows early detection of problematic health issues and reduces the risk of these becoming health emergencies.

Relationship to other Projects:

For Pass 2 PRMC was only required to do one project. However, our Pass 1 project’s success will be determined on process improvements and reporting from the outcomes of this Pass 2 project. The pass 1 project has identified a need for data, which is not readily available today. Once data is available, training will enhance our ability to effectively utilize information to make system process improvements resulting in improved patient outcomes.

Relationship to Other Performing Providers’ Projects in the RHP:

Relationship to other Performing Provider Projects is unable to be determined at this time.

Plan for Learning Collaborative:

University Health System, as the RHP 6 anchor, will promote and facilitate learning collaborative. Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following: Identify participants; Establish Learning Collaborative goals; Develop a calendar of regular meetings, site visits, and/or conference calls; Develop a plan to communicate ideas, data, and successes across the region and state; Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices; Adopt metrics to measure success.

Project Valuation:

Peterson values each project based on the specific needs of the community, projected impact on community health outcomes, level of advancement to the healthcare delivery system, and the time, effort and clinical resources necessary to implement each portion of this project.
Evidence from research indicates that quality improvement is critical to achieving better health outcomes and closing the gaps between what we know and what we do in health care. In addition, there is growing evidence that investments in diabetes quality improvement can yield a significant return on investment both in terms of cost savings and improved quality of life for people with diabetes.

Peterson Regional Medical Center is licensed for 125 acute care beds. The diabetic population in calendar year 2012 consisted of 3719 patients. 11% of the visits were provided for the Medicaid/Indigent/Self-pay subpopulation. Cost avoidance is being limited by data availability and budget constraints on use of external resources. PRMC lacks the availability of appropriately trained personal to write quality improvement reports from data collected from within our organization. The true value is establishing the capability that will last throughout the organization’s history. The implementation cost of this project is estimated to be $436,636. This project will address the community health care needs by providing the tools to reach Pass 1 data and process improvement goals. In calendar year 2012 PRMC’s baseline diabetic population group had a total of 3,719 patients with 1,226 inpatient admissions for a total of $28.8 million in charges. PRMC’s Pass 1 initiative estimates an average annual community healthcare savings of $2.9 million by reducing the rate of inpatient admissions (as a percentage of the total diabetic population) by 10%. Without process improvement methodologies, the capability to enhance reporting ability and integrity failure to meet improvement outcomes is imminent. Components of evidence based improvement methodologies combined with real-time data availability increase the likelihood of desired outcomes.

"The ultimate measure by which to judge the quality of a medical effort is whether it helps patients (and their families) as they see it. Anything done in health care that does not help a patient or family is, by definition, waste, whether or not the professions and their associations traditionally hallow it" (Don Berwick, 1997).
<table>
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<th>IT-9.2</th>
<th>Reduce Emergency Department visits for target condition - Diabetes (Standalone)</th>
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**Milestone 1**

**P-5**: Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement.

**Metric 1 [P-5.1]**: Increased collection of patient experience and/or quality measures data

*Baseline:* Currently no diabetic population specific reporting is available.

*Goal:* Define specific metrics, data collection requirements and reporting format for the following reports: scheduled follow-up appointments post hospitalization,

**Metric 2 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends).

*Baseline:* 0

*Goal:* Fifty staff members trained in basics and five trained in advanced quality and efficiency principles

*Data Source:* HR and Training Programs

**Metric 2 [P-6.2]:** Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle

**Milestone 2**

**P-6**: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends).

**Metric 1 [P-6.1]:** Increase Number of staff trained in quality and efficiency improvement principles

*Baseline:* Number of staff trained

*Goal:* Fifty staff members trained in basics and five trained in advanced quality and efficiency principles

**Data Source:** HR and Training Programs

**Metric 2 [P-6.2]:** Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle

**Milestone 3**

**I-7**: Implement quality improvement data systems, collection, and reporting capabilities.

**Metric 1 [I-7.1]:** Increase the number of reports generated through these quality improvement data systems

*Goal:* Generate monthly quality reports as defined in Milestone 1

*Data Source:* EMR

**Metric 2 [I-7.2]:** Demonstrate how quality reports are used to drive rapid-cycle performance improvement.

Number of performance activities that were designed and implemented based on the data in the reports.

*Goal:* One per month

**Milestone 4**

**I-8**: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures.

**Metric 1 [I-8.1]:** Submission of quality dashboard or scoreboard

*Goal:* One

*Data Source:* Quality Improvement Data Systems

**Metric 2 [I-8.2]:** Demonstration of how quality dashboard is used to drive rapid-cycle performance improvement.

Number of performance activities that were designed and implemented based on the data in the reports.

*Goal:* Utilize dashboard data to drive identified process improvement projects

*Data Source:* Documentation from quality improvement office
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<th>Data Source:</th>
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<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $ 375,836</td>
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| Milestone Bundle Amount: $414,221 | Milestone Bundle Amount: $452,586 | Milestone Bundle Amount: $455,512 | Milestone Bundle Amount: $375,836 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,698,155
Identifying Project and Provider Information:
Title: 1.9.2 Improve Access to Specialty Care: Improve Outcomes for Diabetic Pregnancies
Unique RHP ID#: 136491104.1.1 – PASS 1
Provider Name: Southwest General Hospital
TPI: 136491104

Project Summary:

Provider Description:
Southwest General Hospital is a 327-bed, acute care hospital in San Antonio, Texas serving residents of South San Antonio and surrounding areas. RHP 6 encompasses 20 counties and covers 24,734 square miles, comprising about 9.5% of the total land area of Texas.

Intervention(s):
Southwest General Hospital proposes to develop and implement a Gestational Diabetes program to educate and monitor patients throughout their pregnancy, therefore improving fetal outcomes. The project will provide specialty care services and providers to better accommodate the high demand for peri-natal services and thus have increased access to services. The project will include a structured program that involves both Obstetricians and Maternal Fetal Medicine physicians, perinatal nurses, and a diabetic educator. The program will include a process to ensure transparent, standardized referrals across the continuum of care.

Need for the project:

- RHP 6 pregnant women currently have limited access to resources to care for at risk or diagnosed with gestational diabetes. The program will seek to enhance ease and availability of care resources.
- Bexar County, which has the highest number of births in the state of Texas, has a higher adolescent (ages 13-17 years) pregnancy rate than Texas, with an average of 30.6 per 1000 women compared to 26.1 for the state. This project will assist with meeting a serious healthcare gap in RHP 6.
- Women of Hispanic origin have a 5-8% chance of developing gestational diabetes compared to a 1.5-2% risk in non-Hispanic white women. Approximately 54% of the population in RHP 6 is of Hispanic origin. This differs from the state as a whole, which is 46% Anglo and 38% Hispanic. With proper diet, medication and monitoring, complications from gestational diabetes can be controlled. A strong referral network will support achieving this program goal.
- Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources.
- The high percentage rate of stillbirths, premature deliveries and low birth weight babies, preterm labor, and birth trauma related to diabetes in pregnancy presents a need for these services.
- The Gestational Diabetes Program will assist with improving the health care delivery infrastructure to better serve the Medicaid and uninsured residents of South San Antonio and surrounding areas. At Southwest General Hospital currently, 89.4% of obstetrical patients are Medicaid and uninsured mothers and babies.
- The program will build on an existing Maternal Fetal Medicine program which is comprised of Obstetricians, Maternal Fetal Medicine Physicians, Diabetes Educators, and Perinatal Nurse Practitioners. Outreach efforts will serve to identify and reach key rural areas currently experiencing difficulty with access to care.

**Target population:**

The target population will be pregnant teens and women at risk for or diagnosed with gestational diabetes in RHP 6. Currently, Southwest is seeing approximately 620 mothers annually for care related to Gestational Diabetes.

The focus will be on the first trimester of pregnancy with an added focus on Hispanic adolescents and women.

**Category 1 or 2 expected patient benefits:**

- To provide a specialty gestational diabetes outreach center with an established associated maternal fetal medicine program.
- To decrease the percentage of low birth weight babies resulting from undiagnosed or untreated gestational diabetes.
- To increase the total volume of patients seen at the specialty clinic by 6% from baseline DY 3 to DY4.

**Category 3 outcomes:**

Our goal is to reduce the number of babies weighing less than 2500 grams at birth by 5% in year 4 and by 7% in year 5 by screening, early identification, intervention, treatment and provision of preventive care for the pregnant women with gestational diabetes.

**Project Description:**

Southwest General Hospital proposes to develop and implement a Gestational Diabetes program to educate and monitor patients throughout the pregnancy, therefore improving patient outcomes.

The project for Southwest General Hospital is designed to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for services and thus have increased access to services. Southwest General Hospital will develop and implement a Gestational Diabetes program to educate and monitor patients, therefore, improving fetal outcomes. We propose providing a structured program that involves referrals to both Obstetricians and Maternal Fetal Medicine physicians, perinatal nurses, and a diabetic educator.

Through the goal of improving access to specialty care, the project will impact the following:

- Clinic hours will be established to meet needs through flexibility of hours (early am and evening) as well as routine hour visits
- Gestational diabetes clinics will be established in one additional area of RHP 6 with highest pregnancy rate
- Quality improvement efforts will focus on use of rapid cycle improvement methodologies
Goals and Relationship to Regional Goals:
The goal of this project is to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for services and thus have increased access to services. A structured education program and ongoing patient monitoring will have as a goal the improvement in clinical outcomes for women with Gestational Diabetes.

Project Goals:
- Provide a Gestational Diabetes Program for the RHP 6 region
- Increase access to care for RHP 6 pregnant women at risk for or diagnosed with gestational diabetes
- Decrease the percentage rate of stillbirths, premature delivery and low birth weight babies, preterm labor, and birth trauma related to diabetes in pregnancy

This program meets the following regional goals:
- The Gestational Diabetes Program will contribute to assuring patients receive high-quality, patient centered care with the goal of improved outcomes for mother and baby
- The Gestational Diabetes Program will assist with improving the health care delivery infrastructure to better serve the Medicaid and uninsured residents of South San Antonio and surrounding areas. At Southwest General Hospital currently, 89.4% of obstetrical patients are Medicaid and uninsured mothers and babies.
- The program will build on an existing Maternal Fetal Medicine program which is comprised of Obstetricians, Maternal Fetal Medicine Physicians, Diabetes Educators, and Perinatal Nurse Practitioners. Outreach efforts will serve to identify and reach key rural areas currently experiencing difficulty with access to care. The Birthplace at Southwest General Hospital has provided care to women, including teens, with gestational diabetes with excellent outcomes. We have the ability and knowledge to provide outlying communities with the resources needed to manage patients with Gestational Diabetes. The establishment of standardized referral and work up guidelines is critical to program success.

Challenges/Issues Faced By Provider:
- Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources
- Difficulties with the Medicaid authorization processes may lead to physicians to drop many Medicaid patients

5-year Expected Outcome:
Through an increase in access, the Birthplace at Southwest General Hospital will improve clinical outcomes for pregnant women with Gestational Diabetes, therefore, anticipate decreasing
the rate of stillbirths, premature delivery and low birth weight babies, macrosomia, preterm labor, and birth trauma related to diabetes in pregnancy.

1 RHP 6 Community Needs Assessment, September 2012.

**Starting Point/Baseline:**

The baseline for the program will serve as the foundation to further develop and grow the Maternal Fetal Medicine Program at Southwest General Hospital to care for local and outlying regions of RHP 6 with a high quality gestational diabetes specialty care service line. The baseline number of participants as well as the number of providers begins as 0 for both in DY2.

The Birthplace at Southwest General Hospital has provided care to women, including teens, with gestational diabetes with excellent outcomes. We have the ability and knowledge to provide outlying communities with the resources needed to manage patients with Gestational Diabetes.

Baseline number of available appointment for Gestational Diabetes patients is at capacity in existing care delivery model and is limited by space and time. The ability to establish outreach clinics served by specialty consultants in key need areas will provide improved access to mothers requiring screening, care, and management of diabetes, as required. The establishment of these clinics will also reduce waiting time for routine appointments and foster improved participation and compliance with treatment plans for diabetes and pregnancy management. Currently, Southwest is seeing 620 mothers annually for care related to Gestational Diabetes.

**Rationale:**

Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources. It is estimated that between 2.5 percent and 4 percent of women in the United States will develop gestational diabetes during pregnancy. Gestational diabetes place these women at a greater risk for pregnancy complications including preeclampsia, prematurity, macrosomia (birth weight greater than 9lbs 15ounces), neonate respiratory difficulties, neonate hypoglycemia, birth injury and stillbirth. According to the Texas Department of Human Services, in 2007, 50.3% of the premature births were from Hispanic mothers. Women of Hispanic origin have a 5-8% chance of developing gestational diabetes compared to a 1.5-2% risk in non-Hispanic white women. Approximately 54% of the population in RHP 6 is of Hispanic origin. This differs from the state as a whole, which is 46% Anglo and 38% Hispanic. With proper diet, medication and monitoring, complications from gestational diabetes can be controlled.

According to the Regional Healthcare Partnership 6 Community Needs Assessment (September 2012), Diabetes is one of the major causes of premature death in the U.S. and disproportionately affects some racial and ethnic populations. The percentages of low birth weight babies and diabetes among adults are similar for the region and Texas, with an average between 8% and 10%. Bexar County, which has the highest number of births, has a higher adolescent (ages 13-17 years) pregnancy rate than Texas, with an average of 30.6 per 1000 women compared to 26.1 for the state. This project will assist with meeting a serious healthcare gap in RHP 6.

The Birthplace at Southwest General Hospital has provided care to women, including teens, with
gestational diabetes with excellent outcomes. We have the ability and knowledge to provide outlying communities with the skills, knowledge, and clinically competent resources necessary to manage patients with Gestational Diabetes and for patients to manage self through outreach services in collaboration with rural healthcare teams. All pregnant women should be screened for gestational diabetes because of its serious risks; however, a recent study has found that only 68 percent of all pregnant women were screened\textsuperscript{6}. With proper diet, medication, and monitoring, complications from gestational diabetes can be controlled.

Unique community need identification number the project addresses:

- CN.5 -Lack of interconceptional and prenatal care for women and preventative pediatric care results in poor maternal and child health outcomes

As stated previously, Southwest General has provided a Maternal Fetal Medicine program for the last 12 months. The expansion of the program to RHP 6 areas of acute need will be a new initiative requiring space as well as human and material resources. The ability to model the existing program is an asset in development and implementation of the project.

\textsuperscript{2}RHP 6 Community Needs Assessment, September 2012.  
\textsuperscript{5}RHP 6 Community Needs Assessment, September 2012.  
\textsuperscript{6}RHP 6 Community Needs Assessment, September 2012.

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcome:

- IT- 8.2 Percentage of Low Birth-weight births

Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources\textsuperscript{2}. The potential for gestational diabetes going unidentified is extremely high in the region. The screening, identification, education and provision of prenatal care are critical to impact the above outcome measures.

According to the Texas Department of Human Services, in 2007, 50.3% of the premature births were from Hispanic mothers. Women of Hispanic origin have a 5-8% chance of developing gestational diabetes compared to a 1.5-2% risk in non-Hispanic white women. Approximately 54% of the population in RHP 6 is of Hispanic origin\textsuperscript{6}. This differs from the state as a whole, which is 46% Anglo and 38% Hispanic\textsuperscript{5}. With proper diet, medication and monitoring, complications from gestational diabetes can be controlled. The monitoring of the above metric will serve to evaluate the outcomes associated with education related to proper diet, medication management, and complication prevention provided through a gestational diabetes program focused on screening and identification of actual and potential residents in RHP 6 with gestational diabetes.

The monitoring initiative is new to Southwest General Hospital; however, the outcome measure
of low birth weight is critical to evaluation of the program outcomes as well as evaluation of the entire population served by the facility. The monitoring and evaluation outcomes will serve to further develop the diabetes program and will serve as the basis for identification of additional clinical care programs.

### Relationship to other Projects:

The development of a Gestational Diabetes program service line would inter-relate to the following projects:

- 1.9: Diabetes service line expansion to address the specialty problem of gestational diabetes;
- 2.6: Implementation of evidence-based health promotion and disease prevention program for gestational diabetes;
- 2.12: The implementation of a comprehensive care transition program for Post Partum follow-up and disease follow-up and monitoring.

The project aligns with Category 4 Population focused measures which are the following: RD-1 Potentially Preventable Admissions related to Diabetes. Diabetic short term complications of patients cared for in program and post delivery require admission for short term diabetic complications. Through the identification of barriers and facilitators of post partum follow up in women with recent gestational diabetes, the incidences requiring admission are hypothesized to be minimal post participation in SWGH proposed program.

### Relationship to Other Performing Providers’ Projects in the RHP:

Potential members of learning collaborative based on early review and identification of projects. Further detail required to assess comparability and potential for collaboration.

1. CHRISTUS Santa Rosa Hospital – Implement Evidence based Health Promotion Programs; and Expand Specialty Care Capacity
2. University Hospital; Baptist Medical Center; CHRISTUS Hospital of San Antonio; Methodist Hospital; Dimmitt County Memorial Hospital; Val Verde Regional Medical Center; and Connally Memorial Medical Center – Expand Specialty Care Capacity

### Plan for Learning Collaborative:

At this time, without further background information and detail on projects for RHP 6, a plan for participation in a RHP-wide learning collaborative with other similar projects is not possible. The potential for collaboration with above identified projects and providers is critical to best practice identification and performance improvement projects.
### Project Valuation:

- **Achieve Waiver Goals:**
  
  “Initiatives under the DSRIP program are designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve”. Southwest General will develop the gestational diabetes program, provide qualified members of the Healthcare team, to include Obstetricians and Maternal Fetal Medicine providers, to support patient education and care, and allocate space, equipment, and resources to recruit program participants.

- **Addresses Community Needs:**
  
  As previously outlined the community and the RHP as a whole are critically challenged to provide timely prenatal care and reduce the incidence of gestational diabetes. Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources⁷. The potential for gestational diabetes going unidentified is extremely high in the region. The screening, identification, education and provision of prenatal care are critical to impact the above outcome measures.

  ⁷RHP 6 Community Needs Assessment, September 2012.

- **Project Scope:**

  Southwest General Hospital has a known reputation on the Southside of San Antonio related to obstetrical care. In late 2011, the organization launched a maternal fetal medicine program which has enhanced the ability to reach outlying regions and establish a program to identify and manage gestational diabetes in a manner which demonstrates practices based on evidence and supported by clinical outcomes. The expansion of the program to outlying communities will further enhance care but also extend high quality preventive care and education for the region. The program framework is developed and requires the expansion and planning to serve and identify a larger patient base and establish outreach programs to impact care for the patient population.

- **Project Investment:**

  Many of the resources required to support the physician component of the proposed project is in place. The major investment centers on midlevel care provider recruitment and salaries. Additionally, support staff, space, additional equipment needs, travel, marketing, and educational materials will require hospital dollars to support program implementation and sustainability.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tr>
<td>136491104.1.1 PASS 1</td>
<td>1.9.2</td>
<td>1.9.2 (A,B,D)</td>
<td>1.9.2 Improve Access to Specialty Care: Improve Outcomes for Diabetic Pregnancies</td>
<td>Southwest General Hospital</td>
<td>TPI - 136491104</td>
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<tr>
<td>136491104.3.1</td>
<td>3.IT-8.2</td>
<td>Percentage of Low Birth Weight Births</td>
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</tbody>
</table>

**Milestone 1**
(P-1) Conduct a specialty care gap analysis as a means to describe the community need for a Gestational Diabetes program

P-1.1. Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).
- a. Data Source: Needs Assessment
- b. 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

Data Source: Documentation of the needs assessment and

**Milestone 2**
(P-11) Launch/expand a specialty care clinic

P-11.1. Metric: Establish/expand specialty care programs: Diabetes Outreach programs
- a. Number of patients served by specialty care clinic
- b. Data Source: Documentation of new/expanded specialty care clinic
- c. Rationale/Evidence: Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. Additionally, specialty care clinics allow for enhanced care coordination for those patients requiring intensive specialty services.

Data Source: Documentation of increase over Milestone 6 baseline by 10%
<table>
<thead>
<tr>
<th>Base Line: Gap Analysis has not been performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Submission of Gap Analysis Findings</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $ 2,112,112</td>
</tr>
</tbody>
</table>

**Milestone 2**
(P-6) : Develop and implement standardized referral and work-up guidelines

Metric: Referral and work-up guidelines

a. Documentation of referral and work-up guidelines

Data Source: Referral and work-up policies and procedures documents

Goal: Development of referral and work-up policies and procedures.

Milestone 2 Estimated Incentive Payment: $ 2,112,112

<table>
<thead>
<tr>
<th>Documentation of Gestational Diabetes Outreach Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: One Primary Gestational Diabetes Program within Maternal Fetal Medicine Program</td>
</tr>
<tr>
<td>Goal: Establish one Outreach Gestational Diabetes Program</td>
</tr>
</tbody>
</table>

Milestone 3 Estimated Incentive Payment: $231,403

**Milestone 4**
(P-5) Provide reports on wait time from receipt of referral to actual referral appointment

Metric: Generate and provide reports on time to appointment (to providers, staff, and referring physicians).

a. Numerator: Sum, for all referrals, of the number of days between when request for referral is received from referring provider and the referral appointment during the reporting period.

b. Denominator: Total number of referrals during the reporting period.

c. Data Source: EHR, Referral from Milestone 4

goal: Decrease wait times by 1 day based on Milestone 4 findings

Milestone 5 Estimated Incentive Payment: $ 232,075.50

**Milestone 6**
(I-33): Increase specialty care capacity using innovative project option.

Metric: Increase percentage of target population reached.

a. Numerator: Number of individuals of target population reached by the innovative project.

b. Denominator: Number of individuals in the target population.

c. Data Source: Documentation of target population reached, as specified in the project plan.

d. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching its targeted population.

Baseline: Number of target population patients seen in Gestational Diabetes Program in DY3

Goal: Increase percentage of target population reached by 6% as defined by numbers in target population for RHP6

Milestone 7 Estimated Incentive Payment: $191,714.50

**Milestone 8**
(I-30) Reduce the waiting times for next routine appointment, at the Gestational Diabetes Clinic, for patients with Gestational Diabetes by additional 2.5 days.

I-30.1. Metric: Next routine appointment of more than X calendar days and/or to no more than X of X specialty clinics or specialty practices

a. Time to next available appointment; number of clinics with time to next available appointment not greater than 2.5 days

b. Data Source: Performing Provider appointment scheduling system

c. Rationale/Evidence: This measure addresses the accessibility of specialty care clinics.

Data Source: Practice management or scheduling systems or other

Baseline: Wait times for Milestone 4
<table>
<thead>
<tr>
<th>Management system, Administrative records. (Generated Reports on file). d. Rationale/Evidence: This measure allows for assessment of Referral Management System efficacy. Baseline: No data collected. Goal: Identify wait times from referral to appointment. Milestone 4 Estimated Incentive Payment: $231,403</th>
<th>Milestone 6 Estimated Incentive Payment: $232,075.50</th>
<th>Goal: Decrease wait times by additional 2.5 days. Milestone 8 Estimated Incentive Payment: $191,714.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $424,224</td>
<td>Year 3 Estimated Milestone Bundle Amount: $462,806</td>
<td>Year 4 Estimated Milestone Bundle Amount: $464,151</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,743,608
Identifying Project and Provider Information:
Title: 1.1.1 Establish more primary care clinics: University Hospital
Unique RHP ID#: 136141205.1.1 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): The Health System will partner with Federally Qualified Health Centers to increase access to women’s health services for residents of Bexar County, Texas by establishing clinical sites and increasing number of primary care visits to enhance access to early preventive care. Combined, these practices can encourage and empower individuals to make healthy decisions that can lead to improved health outcomes in the area of maternal, infant and child health.

Need for the project: Rapid population growth alongside concentrations of low-income, under and uninsured residents underscore the importance of improving access to preventive health services that respond to the health service needs of the population. Focusing on maternal, child and infant health is considered an important opportunity to identify existing health conditions in women such as diabetes, hypertension, poor nutrition and to prevent future health problems for women and their children. Factors that can impact maternal and child health include living in poverty, limited access to prenatal care, nutrition and age. The rate of uninsured in Bexar County is 23% further highlighting the need for increased access.

Target population: The target population includes Medicaid-funded (19%) and uninsured (43%) individuals who represent 62% of the patient population served by the Health System. In addition focus will be placed on residents located in rapidly growing areas of Bexar County and in particular the central Northern sector of the county where almost four out ten individuals have no usual source of medical care or have not received a medical checkup in the past year. This area also has a number of a high number of low income, uninsured, minority residents who suffer from multiple chronic conditions

Category 1 or 2 expected patient benefits: The anticipated 5 year goal is to increase primary care encounters by 20% over baseline (or 7,524 encounters) by enhancing access to preventive health care targeting improved birth outcomes in both mother and child.

Category 3 outcomes: IT-8.1 Timeliness of Prenatal/Postnatal Care; IT-8.5 Frequency of Ongoing Prenatal Care; IT-8.2 Percentage of low birth weight births (CHIPRA/NQF #1382)

- **DY4** –
  - Increase Timeliness of Prenatal/Postnatal Care by TBD% from baseline.
• Increase Frequency of Ongoing Prenatal Care by TBD% from baseline.
• Decrease Percentage of Low Birth-weight births by TBD% from baseline
  • DY5 –
    • Increase Timeliness of Prenatal/Postnatal Care by TBD% from baseline.
    • Increase Frequency of Ongoing Prenatal Care by TBD% from baseline.
    • Decrease Percentage of Low Birth-weight births by TBD% from baseline

Project Description:

University Health System will partner with Federally Qualified Health Centers (FQHCs) to increase access to women’s health services for residents of Bexar County, Texas by establishing clinical sites and increasing number of primary care visits to enhance access to early preventive care. Combined, these practices can encourage and empower individuals to make healthy decisions that can lead to improved health outcomes in the area of maternal, infant and child health. In Bexar County, as elsewhere, low income, uninsured, minority populations have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long wait times have a significant negative impact on patient and provider satisfaction and quality of care, and discourage people from using health care proactively. Recruitment of providers to serve a medically compromised population will also be challenging. The 5 year goal is to expand delivery of women’s preventive service and thereby create access to primary care services for high risk populations translating into additional 7,524 patient encounters. Establishing a new clinic location that provides much needed women’s preventive health services addresses many of the challenges faced by patients including delays in scheduling appointments, long wait times and overall access to healthcare.

The project addresses the following regional goals:
  • Further develop and maintain a coordinated care delivery system

Starting Point/Baseline:

As of September 30, 2012, there are 0 patient encounters at this new location for base year.

Rationale:

In the United States, safety-net hospital systems remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. In the era of healthcare reform, safety-net hospitals will remain critical to responding to the mandate of providing medical care that is accessible, integrated, and patient-centered. In addition, the evidence makes clear that carefully tailored health services interventions can lead to the establishment of a usual source of care, improve adherence to clinical care and treatment, and strengthen evidence-based clinical preventive service delivery to economically vulnerable, uninsured or underinsured populations.

In Bexar County, Texas, rapid population growth alongside concentrations of low-income, under and uninsured residents underscores the importance of improving access to preventive health services that respond to the health service needs of the population. Focusing on maternal, child and infant health is considered an important opportunity to identify existing health conditions in
women such as diabetes, hypertension, poor nutrition and to prevent future health problems for women and their children. Factors that can impact maternal and child health include living in poverty, limited access to prenatal care, nutrition and age. The rate of uninsured in Bexar County is 23% further highlighting the need for increased access.

To combat these disparities and increase healthcare access, University Health System; the major safety-net hospital for South Central Texas proposes to expand its patient-centered medical home. This is considered an integrated model of health service delivery that focuses on providing high quality, affordable, accessible care alongside a clinical practice that is efficient, evidence-based and utilizes inter-operable information systems to address primary, urgent and specialty care needs.

This project addresses CN.3. Specifically, the local identified need of increased access to medical health services due to high rates of uninsured and a shortage of health care providers is being addressed. This program strengthens healthcare linkages with local community partners enhances access to health care services by expanding clinical services and increasing the number of healthcare providers. No additional federal funds will be utilized for this project due to partnership with FQHC. This will be a partnership of co-location with a lease agreement involved.

The primary project component is to improve geographical coverage and access to clinical sites and increase number of primary care visits to enhance access to early preventive care with particular focus placed on addressing maternal and child health. This evidence-based model of care shifts focus from clinical service provision to the patient, their families, and their community. Establishing a long-term, trusting relationship assures patients receive the right care, including recommended clinical preventive services, at the right time, in the right setting.

Implementation of this program will ensure patients have access to continuity of primary and preventive care services. Strategies include redesigning our clinical workflow to reduce wait times, assure timely scheduling of appointments, deliver clear communication and messaging between patients and health care teams, provide data systems to support population health management, establish effective case management and care coordination, and support patient self-care, development, and accountability, and develop performance reporting and improvement plans using LEAN concepts to reduce waste.

Measures of performance will include both process and outcomes measures that assess progress towards implementation milestones. These include: 1) measures of clinical expansion (establishment of patient-centered medical home site), 2) integration and access (expanded services that address target population needs), and 3) quality of care and cost-effectiveness. In summary, establishing this patient-centered, clinical preventive model of care strengthens the our mission and responds to national health aims of delivering high quality care, improving population health and reducing healthcare costs.

Related Category 3 Outcome Measure(s):

- Timeliness of prenatal/postnatal care (IT-8.1)
- Frequency of ongoing prenatal care (IT-8.5)
Outcome Domain: 8-Perinatal Outcomes

Specific outcomes selected for this project were based on evidence of effectiveness regarding the importance of initiating early of prenatal Care (PNC) and helping to reduce late prenatal care entry during pregnancy which has been shown to significantly reduce the potentially deleterious effects of both normal and high-risk pregnancy outcomes including: 1) premature birth, 2) low birth weight, 3) maternal hypertension and 4) gestational diabetes (Alexander and Korenbrot, 1995; Tossounian, Schoendorf and Kiely, 1997; Alexander and Kotelchuck, 2001; Atrash et al., 2006). In addition, the delivery of postnatal care primarily through preventive screening conducted at specific developmental milestones can help reduce maternal death or disability as a result of undiagnosed conditions (Healthy People 2020).

IT-8.1 Timeliness of Prenatal/Postnatal Care 262 (CHIPRA Core Measure/NQF #1517) (Nonstandalone measure)

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

b. Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year

c. Data source: EHR, claims

d. Rationale/Evidence: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

• Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

• Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

IT-8.5 Frequency of ongoing prenatal care (AHRQ266/CHIRPA267) (Non-stand alone measure)

a. Numerator: Women in the denominator sample who had an unduplicated count of less than 21%, 21-40%, 41-60%, 61-80%, or more than 81% of expected visits, adjusted for the month of pregnancy at enrollment and gestational age.

b. Denominator: Women who delivered a live birth during the measurement yr.

c. Data source: EHR, Claims

d. Rationale/Evidence: This measure looks at the use of prenatal care services. It tracks
Medicaid-enrolled women who had live births during the past year to determine the percentage of recommended prenatal visits they had. Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems. The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early as possible in the first trimester of pregnancy. Visits should follow a schedule:

- Every 4 weeks for the first 28 weeks of pregnancy
- Every 2 to 3 weeks for the next 7 weeks
- Weekly thereafter until delivery

**IT-8.2 Percentage of low birth weight (CHIPRA/NQF#1382)**

a. Numerator: The number of babies born weighing <2,500 grams at birth)
b. Denominator: All births
c. Data Source: EMR, Claims
d. Rationale/Evidence: Women who receive prenatal care are more likely to have 1) access to screening and diagnostic tests that can help identify problems early; 2) services to manage developing and existing problems; and 3) education, counseling, and referrals to reduce risky behaviors like substance use and poor nutrition (Healthy People, 2020, March of Dimes, 2010). National studies demonstrate that almost 1 out of 4 women still do not receive the full benefits of prenatal care (PNC). For example, between 1980 and 2001, the proportion of women who received PNC in the first trimester increased only moderately from 76% to 83% while a more recent investigation found that in 2003 and 2004 the percentage of women who reported receiving PNC (84%) remain unchanged (Martin et al., 2002). Studies also demonstrate an association between late entry into PNC and impact on birth outcomes including low birth weight, preterm birth and infant mortality. In 2006, as in previous years, non-Hispanic black and Hispanic women were more than twice as likely as non-Hispanic white women to receive care late (beginning in the 3rd trimester) or to receive no care at all (March of Dimes, 2010).

**Relationship to other Projects:**

This Project is related to:

**Category 2:**

136141205.1.5: Expand specialty care; Behavioral health services
Mental health conditions are prevalent among women of reproductive age and a substantial proportion goes untreated. Expanding Behavioral health services allows increase access through both women’s health and primary care provider referrals.

92414401.2.2 Enhance/Expand Medical Homes
Increasing access to primary care and women’s services supports the medical home by providing access to specialty and preventive services offered in one location, in close proximity to patient homes and communities.

131641205.2.2 Redesign to Improve Patient Experience
Providing the ability to access healthcare in a timely manner and in locations where services are needed will lead to better patient experience. This can also be replicated with local and regional partners.

131641205.2.3 Apply process improvement methodology to improve quality and efficiencies:
LEAN methodologies will be used to develop and implement improved clinical workflows, provider tools and training for staff in process improvement, and efficient, quality care delivery
Category 4:
Related Category 4 measures include potentially preventable admissions measures in RD-1, 30 day readmissions in RD-2, Patient Satisfaction in RD-4.1 and RD-4.2.

Relationship to Other Performing Providers’ Projects in the RHP:
92414401.1.1 Expand training of the primary care workforce
Training future providers in primary care will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

Plan for Learning Collaborative:
This project lends itself to participation in a learning collaborative as other Performing Providers in RHP6 seek to develop primary care services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve primary care access.

Project Valuation:
The project achieves the waiver goal and meets community needs by expanding primary care in a predominantly Hispanic, underserved area of Bexar County. This program strengthens healthcare linkages with local community partners and enhances access to health care services to a target population who struggle with poverty, receive acute or emergency healthcare services only, and do not have usual providers.

Review of maternal indicators by funding type for 2010 shows Medicaid births have multiple risk factors associated with preterm or low birth weight deliveries. Total births in 2010 were 25,680 for Bexar County; 48% were Medicaid births, 34% Private insurance, and 18% self pay. Medicaid births had the highest proportion of single mothers (70%), Hispanic mothers (77%) and teen mothers (<18years) 8%, as well as low birth weight babies (<2500 g) (10%), premature babies (13%), and no prenatal care during the first trimester 31%. All these factors are significantly associated with higher risk births.

In addition, many in the target population have chronic disease; with no primary care access these condition will become far more complicated and costly to treat. Access to a primary care medical home been has shown to improve health, improve health care, and lower care costs.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome</th>
<th>Measure(s)</th>
<th>Timeliness of Prenatal/Postnatal Care</th>
<th>Frequency of ongoing prenatal care</th>
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### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
- **P.1 Establish additional primary care clinics**

**Metric 1 [P:1.1]**: Number of additional clinics
- Baseline: 0 primary care clinics in collaboration with local FQHC
- Goal: to have 1 clinical site
- Data Source: Provider schedule IDX at new location
- Milestone 1 Estimated Incentive Payment: $4,479,877
- Year 2 Estimated Milestone Bundle Amount: $4,479,877

**Milestone 2**
- **I:12 Increase primary care clinic/women’s health services volume of visits and evidence of improved access for patients seeking services**

**Metric 1:[I:12.1]**:
- Baseline: 0 primary care encounters September 2012 baseline year.
- Goal: to have 2,200 additional primary care/women’s health services encounters at new clinical site over baseline Year 2
- Data Source: IDX, sunrise and OP activity report
- Milestone 2 Estimated Incentive Payment: $4,887,305
- Year 3 Estimated Milestone Bundle Amount: $4,887,305

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3**
- **I:12 Increase primary care clinic/women’s health services volume of visits and evidence of improved access for patients seeking services**

**Metric 1:[I:12.1]**:
- Goal: to have a total of 2,420 primary care/women’s health services encounters at new clinical site. This is a 10% increase over Year 3 (220).
- Data Source: IDX, sunrise and OP activity report
- Milestone 3 Estimated Incentive Payment: $4,901,513
- Year 4 Estimated Milestone Bundle Amount: $4,901,513

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4**
- **I:12 Increase primary care clinic/women’s health services volume of visits and evidence of improved access for patients seeking services**

**Metric 1:[I:12.1]**:
- Goal: to have a total of 2,904 primary care/women’s health services encounters at new clinical site. This is a 20% increase over Year 4 (484).
- Data Source: IDX, sunrise and OP activity report
- Milestone 4 Estimated Incentive Payment: $4,049,076
- Year 5 Estimated Milestone Bundle Amount: $4,049,076
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $18,317,771
### Identifying Project and Provider Information:

| Title: 1.1.2 Expand existing primary care capacity: University Hospital expanding capacity |
| Unique RHP ID#: 136141205.1.2 – PASS 1 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

### Project Summary:

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access, through Community Medicine Associates (CMA) to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** The Health System will increase access to primary care for residents of Bexar County, Texas by enlarging primary care clinic space, expanding hours of operations at primary care clinic sites and adding more clinical staff.

**Need for the project:** The demand for primary care visits in the Health System’s service area has been growing at a rapid rate. The majority of low-income, under and uninsured residents are concentrated in sectors where access to primary care and social services are limited. The rate of uninsured in Bexar County is 23% highlighting the need for increased access.

**Target population:** Medicaid-funded (19%) and uninsured (43%) individuals represent 62% of the patient population served by the Health System.

**Category 1 or 2 expected patient benefits:** The Health System will improve access for primary care services by demonstrating an increase in volume of services provided in DY2 through DY5. For the baseline year beginning October 1st, 2011 and ending September 30th, 2012, there were 244,382 CMA adult primary care encounters. The secondary goals are to enhance care coordination and reduce emergency room visits, hospital admissions and hospital re-admissions.

- **DY2** – Increase CMA primary care encounters by 2% over baseline; 249,270 expected adult primary care encounters.
- **DY3** – Increase CMA primary care encounters by 4% over baseline; 254,157 expected adult primary care encounters.
- **DY4** – Increase CMA primary care encounters by 6% over baseline; 259,045 expected adult primary care encounters.
- **DY5** – Increase CMA primary care encounters by 8% over baseline; 263,933 expected adult primary care encounters.

**Category 3 outcomes:** IT-9.2 – The goal is to reduce emergency center visits.

- **DY 4** – Reduce emergency center visits for patients with COPD, behavioral health diagnoses, uncontrolled diabetes, and asthma by TBD % from baseline.
- **DY 5** – Reduce emergency center visits for patients with COPD, behavioral health
diagnoses, uncontrolled diabetes, and asthma by TBD % from baseline.

**Project Description:**
Our goal is to increase access to quality primary care in Bexar County. We will accomplish by expanding existing primary care clinic space, expanding hours of operations at primary care clinic sites and expanding the primary care clinic staffing. In Bexar County, as elsewhere, low income, uninsured, and minority populations have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care, and discourage people from using health care proactively. Recruitment of providers to serve a medically compromised population will also be difficult.

The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaborative to be established.

**Relationship to Regional Goals**
This project will further achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth.

**5 Year Expected Outcome for Provider and Patients:**
University Hospital expects to see improvements in clinical outcomes and in reduced utilization of the ER for patients served in this model. The anticipated 5 years goal is to increase primary care access and enhance coordination of care to reduce emergency room visits, hospital admissions and hospital re-admissions.

**Starting Point/Baseline:**
As of baseline year end September 30th, 2012, CMA provided 244,382 adult primary care encounters.
Primary care encounters include: CMA primary care network (Main clinical home, PHC, all locations that provide primary and preventive services)

**Rationale:**
The demand for primary care visits in University Hospital’s primary service area has been growing at a rapid rate. Primary care capacity, resources, infrastructure, and technology are severely limited. Our goal is to increase primary care encounters throughout University Hospital/Community Medicine Associates (CMA) primary care network. In order to provide more preventive, primary, and chronic care in the primary care setting, it is critical to expand primary care capacity. According to the 2010 Healthcare Collaborative reports, the current population of Bexar County increased by 15% between 2000 and 2008 (1.59 million). Racial/ethnic diversity varies greatly within sectors of Bexar County. In 2000, over 80% of the population in South and West Bexar County were Hispanic, while fewer than 30% of North Central and Northeast Bexar County were Hispanic. The proportion of African Americans varies
from under 1% in South Bexar to over 15% in Southeast Bexar. Educational attainment is not distributed equally across Bexar County sub-sectors. Nearly one-third to a half of the population in the South (45.5%), West (42.2%), and Southeast (35.7%) do not have a high school diploma, compared to 6.9% of the population in North Central.

This project addresses CN.3 – Lack of access to medical and dental care due to lack of insurance and provider shortages.

Currently, the demand for primary care services within University Health System exceeds the supply. New initiatives for providing primary care access to the underserved of Bexar county is critical. Our new initiatives will seek to renovate specific clinic locations to provide additional capacity, extend hours of operations to include nights and weekends and hire additional providers to expand patient panel sizes.

**Related Category 3 Outcome Measure(s):**

**IT-9.2 ED appropriate utilization (Standalone measure)**
- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

Reason/rationale for selecting the outcome measure:

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The targeted population will be the CareLink members assigned to University Health System patient centered medical homes. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

**Relationship to other Projects:**

This Project is related to:
136141205.1.3 Implement a Chronic Disease Management Registry
This project will help monitor current and future patient population in University Health System medical homes to improve healthcare outcomes.
136141205.1.4 Introduce, Expand, or Enhance Telemedicine/Telehealth
Telemedicine can be utilized to expand services and access to new clinical sites.
136141205.1.5 Expand specialty care; Behavioral health services
Mental health conditions are prevalent among the population University Health System serves. Expanding Behavioral health services will give the providers access to refer patients in need of these services at new primary care sites.

92414401.2.2 Enhance/Expand Medical Homes
Increasing access to primary care will give patient access to other specialty and preventive services offered in the medical homes

136141205.2.2 Redesign to Improve Patient Experience
Providing the ability to access healthcare in a timely manner and in locations where services are needed will to a better patient experience.

136141205.2.3 Apply process improvement methodology to improve quality and efficiencies: LEAN methodologies will assist all projects in developing tools and training for the staff as it relates to process improvements in the quality and efficiencies in the care provided to the community.

136141205.2.4 Establish/Expand a Patient Care Navigation Program
This project will link much needed care coordination, social support and culturally competent care to vulnerable patient populations at risk for admissions and re-admissions.

136141205.2.5 Use of Palliative Care Programs
Patients in the medical homes with chronic end of life conditions will have an avenue that addresses patient populations who are at risk for suffering, frequent emergency room visits, admissions and death.

Related Category 4 measures include potentially preventable admissions measures in RD-1, 30 day readmissions in RD-2, Patient Satisfaction in RD-4.1 and RD-4.2.

Relationship to Other Performing Providers’ Projects in the RHP:

92414401.1.1 Expand training of the primary care workforce
Training future providers in primary care will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

Plan for Learning Collaborative:
This project lends itself to participation in learning collaboratives as other Performing Providers in RHP6 seek to develop and expand primary care services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve primary care access.

Project Valuation:
The project achieves the waiver goal and meets community needs by expanding primary care in a predominantly Hispanic, underserved area of Bexar County. The demand for primary care has been growing at a rapid rate in Bexar County, and necessitates expanding resources to meet the needs of the population. By expanding clinic space, increasing the number of primary care providers, and expanding clinic hours, this program strengthens healthcare linkages with local community partners and enhances access to health care services to a target population. This population struggles with poverty, utilize acute or emergency healthcare services, and do not have usual providers. In addition, many in the target population have chronic diseases; with no primary care access these condition will become far more complicated and costly to treat. Access to a primary care medical home been has shown to improve health, improve health care, and lower care costs.
<table>
<thead>
<tr>
<th>136141205.1.2</th>
<th>1.1.2</th>
<th>1.1.2 (A - C)</th>
<th>1.1.2 - Expand existing primary care capacity: University Hospital Expanding Capacity</th>
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<tbody>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.4</td>
<td>3.1T-9.2</td>
<td>ED appropriate utilization (Standalone measure)</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt;[P-1]: Expand Existing primary care clinics&lt;br&gt;Metric 1 [P-1.1]: Number of additional square footage for exam rooms at existing clinics Baseline: Total square footage for exam rooms at community clinics at baseline year end September 30th, 2012 Goal: Increase total square feet designated for exam rooms at community clinics by a total of 400 square feet. Data Source: documentation of detail expansion plans/drawings&lt;br&gt;Milestone 1 Estimated Incentive Payment: $1,571,886.66</td>
<td><strong>Milestone 2</strong>&lt;br&gt;[P-5]: Train/Hire additional primary care providers and staff and /or increase the number of&lt;br&gt;Milestone 4&lt;br&gt;[P-4]: Expand the hours of primary care clinic, including evening and/or weekends&lt;br&gt;Metric 1 [P-4.1]: Increase number of primary care clinic hours over baseline&lt;br&gt;Baseline: baseline year of December 31, 2011 primary care hours Goal: add additional 4 hours session at one clinical site Data Source: Provider templates&lt;br&gt;Milestone 4 Estimated Incentive Payment: $2,572,266</td>
<td><strong>Milestone 3</strong>&lt;br&gt;[P-5]: Train/Hire additional primary care providers and staff and /or increase the number of&lt;br&gt;Milestone 5&lt;br&gt;[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services&lt;br&gt;Metric 1 [I-12.1]: Documentation of increased number of visits Baseline: 244,382 CMA adult primary care encounters for baseline year Goal: Increase adult primary care encounters 8% over baseline (263,933 encounters) Data Source: IDX, sunrise and OP activity report&lt;br&gt;Milestone 5 Estimated Incentive Payment: $5,159,487</td>
<td><strong>Milestone 7</strong>&lt;br&gt;[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services&lt;br&gt;Metric 1 [I-12.1]: Documentation of increased number of visits Baseline: 244,382 CMA adult primary care encounters for baseline year Goal: Increase adult primary care encounters 8% over baseline (263,933 encounters) Data Source: IDX, sunrise and OP activity report&lt;br&gt;Milestone 7 Estimated Incentive Payment: $4,262,185</td>
</tr>
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</table>

| Milestone 6<br>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services<br>Metric 1 [I-12.1]: Documentation of increased number of visits Baseline: 244,382 CMA adult primary care encounters for baseline year Goal: Increase adult primary care encounters 6% over baseline (259,045 encounters) Data Source: IDX, sunrise and OP activity report<br>Milestone 6 Estimated Incentive Payment: $5,159,487 | Milestone 7 Estimated Incentive Payment: $4,262,185 |
**Metric 1 [P5.1]**: Documentation of increased number of providers
- **Baseline**: Number of providers in CMA at September 30, 2012
- **Goal**: Add 5 additional providers throughout primary care CMA network
- **Data Source**: provider templates, HR new hire documentation

**Milestone 2**
- **Estimated Incentive Payment**: $1,571,886.66

**Milestone 3**
- **[I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services

**Metric 1 [I-12.1]**: Documentation of increased number of visits
- **Baseline**: 244,382 CMA adult primary care encounters for baseline year
- **Goal**: Increase adult primary care encounters 4% over baseline (254,157 encounters)
- **Data Source**: IDX, sunrise and OP activity report

**Milestone 5**
- **Estimated Incentive Payment**: $2,572,266
Milestone 3 Estimated Incentive Payment: $1,571,886.66

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<th>Year 2 Estimated Milestone Bundle Amount: $4,715,660</th>
<th>Year 3 Estimated Milestone Bundle Amount: $5,144,532</th>
<th>Year 4 Estimated Milestone Bundle Amount: $5,159,487</th>
<th>Year 5 Estimated Milestone Bundle Amount: $4,262,185</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,281,864**
### Identifying Project and Provider Information:

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<tr>
<th>Title:</th>
<th>1.3.1 Implement and use chronic disease management registry functionalities</th>
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<tr>
<td>Unique RHP ID#:</td>
<td>136141205.1.3 – PASS 1</td>
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<td>Performing Provider:</td>
<td>University Hospital</td>
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<tr>
<td>Performing Provider TPI:</td>
<td>136141205</td>
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</table>

### Project Summary:

Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): This project will improve patient care quality by developing and utilizing a master chronic disease management registry that will allow providers to more efficiently monitor a patient's disease status, adherence to treatment plans, medication management as well as tailor delivery of appropriate clinical/care coordination interventions.

Need for the project: The design and utilization of chronic disease registries are considered the first step in providing a population-based approach to fully evaluate quality of care delivered, coverage of clinical preventive services and their impact on condition-specific outcomes for patients with chronic health conditions.

Target population: The target population will include all patients with chronic conditions with a specific focus on adults and children with asthma and COPD. These individuals cost the system about $20 million/year in EC and inpatient visit cost.

Category 1 or 2 expected patient benefits: The project seeks to enroll patients from the largest pediatric sites and pulmonologist/allergy specialist sites into the registry. Registry functionality will be available to the three designated specialties by the end of DY3. Patients will be enrolled during DY4, with a goal of approximately 70% of patients with a diagnosis of asthma in the three target clinic sites enrolled by the end of DY5.

Category 3 outcomes: 136141205.3.5 3.IT-9.2: ED appropriate utilization
- **DY4** – Reduce Emergency Department visits by 5% (300 visits/yr) for adult and pediatric asthma/COPD registry patients assigned to three target specialties.
- **DY5** – Reduce Emergency Department visits by 15% (1500 visits/yr) for adult and pediatric asthma/COPD registry patients assigned to three target clinics.

### Project Description:

This project proposes to develop and use a chronic disease management registry specifically targeting University Hospital’s Medicaid and uninsured patient population diagnosed with asthma/COPD. Providing excellent care to the residents of Bexar County requires reliable, transparent, time-sensitive data. The goal of University Hospital’s Population Health
Infrastructure Initiative (PHII) is to establish a meaningful platform for medical providers to review clinical information with their medical teams and produce better patient outcomes in both inpatient and outpatient settings.

According to the Bexar County Health Collaborative 2010 Health Assessment, prevalence data for asthma in Bexar County reveal an average (13%) comparable to the state’s (12%) and the nation’s (14%). Disparities, however, are found by gender, ethnicity, and locale: Females, African-Americans, and residents of the west and northeast parts of the county are more likely to have asthma. The highest prevalence (16%) among the variables studied is found in residents of the Westside. Implementation and enhanced utilization of Health Information Exchange (HIE) and the Health System’s data warehouse will provide opportunity for accurate, secure patient health care information to be readily accessible to the appropriate providers with the ability of reports being generated for like population through analytic software, enhancing information for clinician decision with respect to patient care.

The Texas Health and Human Services Commission (HHSC) published various reports related to potentially preventable hospitalizations and readmissions. Between 2005 and 2010, HHSC found that RHP 6 had 125,090 potentially preventable hospitalizations, about 8.5% of the entire state. The nine conditions studied included asthma. The hospitalizations are considered “potentially preventable” because “if the individual had access to and cooperated with appropriate outpatient health care, the hospitalization would likely not have occurred.” These hospitalizations amounted to $2.9 billion in hospital charges, roughly $1,700 per adult living in the region’s 20 counties. Specifically, at UHS, when applying national benchmarks to cost, patients with asthma or COPD who were admitted to EC or Inpatient Unit cost the system $19,810,000 last year alone. By tracking key patient information, a disease registry for asthma can help physicians and other members of a patient’s health care team to identify and reach out to patients who may have gaps in their care to prevent complications, which often lead to more costly interventions. Implementation of the registry could save 30% -50%/year of EC/Observation and Inpatient cost of compliant patients.

Goals and Relationship to Regional Goals
This project specifically addresses the regional waiver goals of improving the health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6, reduce health disparities, and further develop and maintain a coordinated care delivery system.

Project Goals:
- Develop a plan to implement/complete the registry to track and assist adult and pediatric patients with asthma/COPD to reduce ED visits.
- Develop and implement a cross-functional team to evaluate registry program.
- Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not a goal, and preventive care status.
- Implement/ expand a functional disease management registry.
- Increase the percentage of patients enrolled in the registry
- Train provider and provider staff to understand and utilize interactive Registries

Challenges:
Challenges to developing a chronic disease management registry for asthma during this wider process include locating appropriately trained and experienced personnel, implementing
new applications, training current staff and executing change management for multiple applications being inserted into the current environment. The end result of the PHII’s asthma/COPD registry project will be a centralized system for data validation, reporting, and analysis.

The PHII will require considerable resources for analysis, design, and implementation into Health System facilities. The Health System will undergo application infrastructure development to efficiently align current applications with new resources to validate synergy of all applications. After development, implementation will ensue at all University Health System sites including the ambulatory network. Training will proceed during and post implementation of applications. Testing applications will follow implementation and precede pilot and go-live stages.

The program will establish a platform for providers, medical staff, administrative executives, service-line personnel to view the same accurate information synthesized through various standardized reports to improve decision-making. The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaboratives to be established.

5-Year Expected Outcome for Provider and Patients:
University Hospital expects to have a fully functional disease-specific registry tailored to meeting the health services needs of its economically underserved population. Further, the registry will assist the health care team in managing patients with asthma/COPD by a) prompting physicians and their teams to conduct appropriate assessments and deliver condition-specific care; b) identifying patients who have missed appointments, are overdue for care, or are not meeting care management goals; c) providing reports about how well individual care teams and the Health System are doing in delivering recommended care to their asthma/COPD patients; and d) stratifying patients into risk categories to target interventions toward patients with the highest needs.

Ultimately, by the end of DY5, data on emergency department use by adult and pediatric asthma/COPD patients will be reduced, reflecting the contributions of the registry to the overall outcome goal, Right Care, Right Setting (OD-9). We anticipate a 30% reduction in EC and inpatient visits. In addition, for health care executives in operations and finance, this initiative will provide transparency of information for enhanced decision-making at executive and service-line levels, which will lead directly to cost-saving opportunities and more efficient processes.

Rationale:
Timely, accurate information is critical to improving health care outcomes. The Population Health Infrastructure Initiative not only establishes the functionalities of a chronic disease management registry, it enhances the data processes relative to a registry, making it a central hub of accurate health system data and information.

Project Components: For the medical care teams on this project, the registry’s asthma/COPD module will enable them to
a) enter patient data into a unique chronic disease registry;
b) actively manage patients using registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community and family
need;
c) use registry reports to develop and implement a QI plan targeted to asthma/COPD management; and
d) conduct quality improvement activities such as rapid cycle improvement, among others.

Milestones and metrics as presented in the following table take the creation of the registry from developing the cross-functional team to evaluate and document the registry’s capability to address the Medicaid and currently uninsured adult and pediatric asthma/COPD patient population, as well as future community needs, through establishing the data elements required for the registry, to implementing the reporting and notification functions necessary to manage individual patients’ care.

This project uniquely targets CN.2 - Address the high prevalence of chronic disease and related health disparities in the community through greater prevention efforts that focus on addressing chronic disease.

Historically, data warehouses have been extremely inflexible and difficult to manage, particularly with regard to sharing data among providers or tracking individual patients. University Hospital’s implementation of its Electronic Medical Record (EMR), with funding assistance from HITECH, positions the organization to enhance and expand the Population Health Infrastructure Initiative (PHII) to establish a meaningful platform for medical providers to review clinical information with their medical teams and produce better patient outcomes in both inpatient and outpatient settings. This platform also provides business intelligence tools to identify opportunities for cost savings and reduce waste. Given the health care disparities among and within the RHP 6 counties, including the prevalence of asthma due to poverty and environmental conditions, the opportunity to gather and share data across performing providers in the region will advance access, reduce disparities, and enhance management of chronic conditions.

### Related Category 3 Outcome Measure(s):

**OD-9 – Right Care, Right Setting:**
**IT-9.2  ED Appropriate Utilization (Stand Alone Measure)**
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

**Reasons/Rationale for selecting the outcome measures:**
Local, state, and national data for Medicaid recipients and the uninsured are unequivocal in showing the lack access to care and subsequent coordination of care for these populations. RHP 6 presents a challenge in this regard as funding sources for performing providers is uneven at best and the disparities in resources are very apparent to patients and provider, alike. The asthma/COPD registry project proposed here will be a powerful tool in the hands of physicians and their health care teams to let them see a truer picture of a patient’s status in terms of medication compliance, appointments kept, latest lab values, among other variables. Studies
into ED use almost always contain a heavy behavioral component, and broad efforts to educate patient populations and to steer them away from EDs have had no effect. An asthma/COPD registry will prompt the provider to engage in face-to-face education and inquiry into an individual’s ED utilization behavior to manage his/her chronic condition. Given the health care disparities among and within the RHP 6 counties, including the prevalence of asthma due to poverty and environmental conditions, the opportunity to gather and share data across performing providers in the region will advance access, enhance management of the chronic condition, and contribute to a reduction in ED utilization.

**Relationship to other Projects:**

The overall Population Health Infrastructure Initiative supports all Health System DSRIP projects through enhanced data collection, centralized reporting, and production of data into accurate information for health care professionals to employ in the areas of telemedicine /telehealth and chronic disease care management.

Category 1: (Project ID: 136141205.1.4) Introduce, Expand or Enhance Telemedicine /Telehealth

Category 2 (Project ID: 92414401.2.1) Apply Evidence-Based Care Management Model to Patients Identified as Having High Risk Health Care Needs

**RD-5. Emergency Department**

Admit decision time to ED departure time for admitted patients (NQF 0497)

a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until

**Relationship to Other Performing Providers’ Projects in the RHP:**

1.3 – Implement a Chronic Disease Management Registry/UTHSCSA: UTHSCSA is the Health System’s partner in delivering care to the county’s Medicaid and currently uninsured populations. We will collaborate on their project to the extent our two overlap, share lessons learned and best practices about registries in general, and support a learning collaborative should one be formed on this topic.

92414401.1.1 - Expand training of primary workforce. All new primary care providers and care manager staff will be trained on the use of the chronic disease registry, and establish a platform for new providers to view the same accurate information synthesized through various standardized reports to improve decision-making, and patient care.

**Plan for Learning Collaborative:**

This project naturally lends itself to participation in learning collaboratives as other Performing Providers seek to establish their own registries or seek to reduce ED utilization in other parts of the region.

**Project Valuation:**

1. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

2. This project addresses community needs by improving access to care for populations with a high prevalence of chronic conditions and reducing disparities in care by providing the...
business intelligence tools to improve programmatic decision-making by locale, ethnicity, gender, or other variables. A significant impact on utilization costs stands to be gained. As noted earlier, asthma was identified by the Texas HHSC as a condition for which potentially preventable hospitalizations and readmissions were observed.

3. When fully implemented – beyond DY5 – which includes developing registries for other highly prevalent chronic conditions, such as diabetes and CHF, as well as eventually sharing the technology among the region’s Performing Providers, the large scope of the project will impact outreach efforts to both physicians and their Medicaid and uninsured patients; will improve proper utilization in the form of increased routine and follow-up patient visits and encounters; will attract and retain physicians in the Health System through; and will promote savings through appropriate ED utilization.

4. This project requires a very large investment as it fits with and enhances federal HIE activities already under way. The hardware, software applications, human resources and time to implement are of the highest organizational priority for the Health System. This particular project targets asthma/COPD, but the scope of utilization for other chronic diseases and in other health care settings is potentially huge.

5. Providers will work with registries to make system of care more efficient and provider time more effective

6. Registry can dramatically improve emergency department providers and primary care provider communication. This improved interaction can ensure a clear message to the patient and more consistent treatment plans
<table>
<thead>
<tr>
<th>136141205.1.3</th>
<th>1.3.1</th>
<th>1.3.1.(A-E)</th>
<th>1.3.1 Implement and use Chronic Disease Management Registry Functionalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.5</td>
<td>3-IT-9.2</td>
<td>ED appropriate utilization</td>
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<tr>
<td><strong>University Hospital</strong></td>
<td><strong>TPI - 136141205</strong></td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 1**
[P-3]: Develop cross-functional team to develop and evaluate registry program.  
**Metric 1 [P-3.1]:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program. Numerator: number of personnel assigned to enter the registry. Denominator: total number of personnel eligible to participate on cross-functional team.  
Baseline: 0 personnel assigned to evaluate the registry.  
Goal: 23 personnel comprising Registry team.  
This team will consist of Specialists in Pulmonology and Allergy, Nurse Specialist in Asthma Education, Team Care Lead, IT specialist for...

**Milestone 4**
[P-10]: Implement cross-functional team to staff registry program.  
**Metric 1 [P-10.1]:** Documentation of personnel (clinical, IT, administrative) assigned to staff registry program.  
Baseline: 0 personnel assigned.  
Goal: 80% of registry positions filled.  
Data Source: HR records.  
Milestone 4 Estimated Incentive Payment: $1,714,844

**Milestone 5**
[P-6]: Conduct staff training using five additional trainers to train on populating and using registry functions.  
**Metric 1 [P-6.1]:**

**Milestone 7**
[P-5]: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status.  
**Metric 1 [P-5.1]:** Documentation of registry automated report. Numerator: number of patients with required information entered in the registry. Denominator: total number of patients with target condition.  
Baseline: 0 capability.  
Data Source: Registry.  
Goal: 1000 (of 2269 total) Asthmatics are visible in the Reporting capability demonstrated. Flow chart...  
Milestone 7 Estimated Incentive Payment:

**Milestone 9**
[P-5]: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not a goal, and preventive care status.  
**Metric 1 [P-5.2]:** Expand/enhance registry report services to provide on-demand, operational, and historical capabilities, inclusive of reports to care providers, managers, and executives to facilitate improved healthcare.  
Goal: Registry report services defined and automated.  
Data Source: Sample report demonstrating registry capability.  
Milestone 9 Estimated Incentive Payment:
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Estimated Incentive Payment: $1,571,886.66</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2</td>
<td>[P-2]: Review current registry capability and assess future needs. Metric 1 [P-2.1]: Documentation of review of current registry capability and assessment of future registry needs. Numerator: Number entered into the registry; 0 if documentation is not provided, 1 if it is provided. Denominator: total patients with the target condition, asthma. Baseline: 0 data elements in submitted. Data Source: Team roster and minutes from team meetings.</td>
</tr>
<tr>
<td>Milestone 3</td>
<td>[P-4]: Implement/expand a functional disease management registry. Metric 1 [P-4.1]: Registry functionality is available in 30 physicians’ offices (20%) of the Performing Provider's sites and includes an expanded number of targeted diseases or clinical conditions. Numerator: Number of sites with registry functionality. Denominator: Total number of sites. Baseline: Registry functionality is available in 0 of the performing provider sites.</td>
</tr>
<tr>
<td>Milestone 4</td>
<td>[I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]: Percentage of asthma patients in the registry. Numerator: Number of asthma patients in the registry. Denominator: Number of patients with asthma diagnosis in the three target clinic sites Baseline: 1150 (50%) of asthma patients are in the registry at T2. Goal: At T3, percentage of asthma patients in the registry increased by 50% to 1700 (75%) Data Source: Registry and EMR</td>
</tr>
<tr>
<td>Milestone 5</td>
<td>Estimated Incentive Payment: $1,714,844</td>
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<tr>
<td>Milestone 6</td>
<td>Milestone 5 Estimated Incentive Payment: $2,579,743.50</td>
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<tr>
<td>Milestone 7</td>
<td>Milestone 6 Estimated Incentive Payment: $2,131,092.50</td>
</tr>
<tr>
<td>Milestone 8</td>
<td>Milestone 7 Estimated Incentive Payment: $2,579,743.50</td>
</tr>
<tr>
<td>Milestone 9</td>
<td>Milestone 8 Estimated Incentive Payment: $2,131,092.50</td>
</tr>
<tr>
<td>Goal: Key data elements required for registry identified</td>
<td>Goal: Registry functionality is available in 30 out of 145 (21%) of the performing provider offices: Family Health Clinic, RBG and Northwest and Southwest Clinics</td>
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<tr>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Data Source: Health System’s EMR</td>
<td>Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation.</td>
</tr>
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</table>

**Milestone 2**

Estimated Incentive Payment: $1,571,886.66

**Milestone 3**

[P-X] Submit a plan to implement/complete the registry to track and assist adult and pediatric patients with asthma to reduce ED visits.

Metric [P-X.1] Written plan is developed and submitted.

Baseline: 0

Goal: Project plan to define team’s tasks and deliverables is completed and submitted

Data Source: Minutes, reports and source documents from cross-functional team meetings and work groups.

Estimated Incentive Payment: $1,571,886.66

**Milestone 6**

Estimated Incentive Payment: $1,714,844
<table>
<thead>
<tr>
<th>Year</th>
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<td>$5,144,532</td>
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<tr>
<td>Year 4</td>
<td>$5,159,487</td>
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<tr>
<td>Year 5</td>
<td>$4,262,185</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $19,281,864
**Identifying Project and Provider Information:**

| Title: 1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: University Hospital Telemedicine Program |
| Unique RHP ID#: 136141205.1.4 – PASS 1 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

**Project Summary:**

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** This project will employ telemedicine services to improve access to specialty care for patients experiencing barriers to such care. With enhanced access and improved care coordination, the telemedicine visits will allow specialists and other members of the health care team to more efficiently monitor a patient's disease status, adherence to treatment plans, and medication management.

**Need for the project:** Telemedicine technology has become increasingly available to clinical practitioners and holds the promise of providing electronic health care services to increase patient access to care. Vulnerable populations that include economically underserved, minority, and uninsured individuals are less likely to either seek or have access to timely clinical interventions and treatment, resulting in emergency room visits and hospital admissions. In Bexar County, as elsewhere in RHP 6, there is a disproportionate population of low-income, uninsured, and minority individuals, who experience chronic conditions. Without regular primary care and timely access to specialists, these chronic conditions are likely to become acute episodes, resulting in preventable hospital admissions.

**Target population:** The target population will include all patients with chronic conditions with a specific focus on adults with diabetes. Medicaid-funded (19%) and uninsured (43%) persons represent 62% of the patient population served by the Health System. According to data provided by the Texas Department of State Health Services, there were 8,863 adult hospitalizations for diabetes long-term complications in Bexar county from 2006 – 2010. University Hospital ranked second in number of admissions.

**Category 1 or 2 expected patient benefits:** In DY4, 10% of adult patients with diabetes referred to specialists from three designated clinics will have received telemedicine visits. By the end of DY5, adult patients with diabetes will be receiving specialty telemedicine visits from five designated clinics and clinics will be performing at least 10 telemedicine visits per month.

**Category 3 outcomes:** 136141205.3.6 3.IT-2.8: Reduce Diabetes Long-term Complications Admission Rate –PQI3
• **DY4** – Reduce Diabetes Long-term Complications Admission Rate by TBD% for adult diabetes patients.
• **DY5** – Reduce Diabetes Long-term Complications Admission Rate by TBD% for adult diabetes patients.

**Project Description:**

University Hospital proposes to employ telemedicine services to the Medicaid and uninsured adult diabetic patient populations in the ambulatory setting.

The Health System’s goal is to increase our ability to provide both primary care and specialty care services to communities currently underserved, with a focus on providing appropriate care, at the right time, in convenient locations. The five-year target goal is to substantially improve primary medical care capacity for Bexar County and the region by employing telemedicine/telehealth technology. This project proposes to employ telemedicine in service to the Health System’s adult diabetic patient population. We want to increase the overall use of telemedicine for consults for specialty areas in the Health System’s Medicaid and uninsured patient populations, such as endocrinology, cardiology, stroke care, and emergency medicine. In Bexar County as elsewhere, there is a disproportionate population of low-income, uninsured, and minority individuals, who often have chronic conditions. Without regular primary care, these chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long wait times have a negative impact on patient satisfaction and quality of care, which ultimately discourages this population from using health care proactively. The Texas Health and Human Services Commission (HHSC) has published various reports related to potentially preventable hospitalizations and readmissions. Between 2005 and 2010, HHSC found that RHP 6 had 125,090 potentially preventable hospitalizations, about 8.5% of the entire state. The nine conditions studied included diabetes. The hospitalizations are considered “potentially preventable” because “if the individual had access to and cooperated with appropriate outpatient health care, the hospitalization would likely not have occurred.” These hospitalizations amounted to $2.9 billion in hospital charges, roughly $1,700 per adult living in the region’s 20 counties. With expanded capacity to provide care through telemedicine, more patients will have access to care, particularly specialty care, which will increase opportunities to prevent disease and avoid hospitalizations, emergency room visits, and re-admissions. In the course of five years, we anticipate a ripple effect of quality of care for the patient and providers, as well as cost savings throughout our health system.

**Project Goal**

The first year’s goal is the acquisition, development, and evaluation of telemodalities, to include robots, teleconferencing software, and telepresence hardware. Multiple pilots in varied settings will allow us to evaluate these technologies. The pilot facilities will employ this equipment to care for the underserved population by providing patients the ability to conference with a provider at a remote, central location. This will enable one provider to service several low-volume clinics in locations throughout Bexar County. An infrastructure environment will be established to support the telemodalities. Nurse and Physician Champions will be established to identify the best candidates for these pilot projects. Maintaining convenient, local, virtual clinics will allow us to extend our reach and provide care to members of the community that might
otherwise not be served, or served at a much higher cost and acuity of care. Expansion of this project to all the Health System’s “hub” clinics, specialty clinics, and eventually, the surrounding counties in partnership with rural hospitals, is the long-term goal for this project beyond the five year plan.

**Relationship to Regional Goals**

This project will further achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth. Specifically, this project will implement a telemedicine program to provide or expand primary care and specialist referral services initially to the health system’s Medicaid and uninsured patients and eventually, to areas identified as needed to the region. The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaboratives to be established.

**Starting Point/Baseline:**

Currently, a telemedicine program does not exist at the Health System’s primary care locations. Therefore, the baseline for the number of participants, as well as number of consults achieved through telemedicine, begins at 0 for DY2.

**Rationale:**

One of the greatest challenges facing the U.S. health care system is to provide quality care to the large segment of the population, which does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers. The use of telecommunications technologies and connectivity has impacted real-world patients, particularly for those in remote communities. This work has translated into observable outcomes such as improved access to specialists; increased patient satisfaction with care; improved clinical outcomes; reduction in emergency room utilization; and cost savings. Nowhere are these benefits more evident than in Texas. Moreover, public and private funding to subsidize care in the state remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own. This project will address the core components of 1.7.1 by employing telemedicine technology in three of the Health System’s clinics to a) provide patient consultations by medical and surgical specialists, as well as other types of health professional using telecommunications and b) conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,”
opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Implementing and expanding telemedicine/telehealth capabilities will allow providers, both in primary care and specialty care, to deliver excellent medical care to our target patient populations throughout RHP 6. Telemedicine/telehealth allows providers to reach into rural areas to provide virtual face-to-face care, while reducing costs and improving patient satisfaction. Milestones and metrics as presented in the following table begin with a needs assessment and identification of specialties to be provided within the project based on regional and community need, while evaluating the technology for upgrades and improvements, followed by implementation in three Health System clinics to address the Medicaid and currently uninsured adult diabetic patient population. Ultimately, by the end of DY5, data on admission rates will show reduced utilization, reflecting the contributions of telemedicine to the overall outcome goal, Potentially Preventable Admissions (OD-2). The RHP Planning Protocol very specifically states HHSC’s goals for employing telemedicine/telehealth: “Specifically, we hope to achieve the following goals for the state’s Medicaid population: increase patients’ timely access to specialty care and reduce geographic barriers; improve efficiency in the referral process by letting specialists divert unnecessary referrals and decreasing the wait time for urgent referrals.” This project is intended to assist the state in these goals.

This project addresses

- **CN.2** – Address the high prevalence of chronic disease and related health disparities in the community through greater prevention efforts that focus on addressing chronic disease and
- **CN.3** – Address the lack of medical and dental health services in the community due to high rates of uninsurance and provider shortages

As noted above, diabetes was identified by the Texas HHSC as a condition for which potentially preventable hospitalizations and readmissions were observed.

University Hospital is already a partner in employing telemedicine in the Bexar County Adult Detention Center, reaching a population that is both literally and figuratively difficult to reach. The experience gives us confidence that expanding this capability to our current clinic patient population and in partnership with the other performing providers in RHP6 will vastly improve management of diabetes and eventually, other chronic conditions, such as CHF, as well as expand access to primary and preventive care. No other sources of federal funding are used for this project.

**Related Category 3 Outcome Measure(s):**

- **OD-2 – Potentially Preventable Admissions**
- **IT-2.8 – Diabetes Long Term complications Admission Rate-PQI3 (Standalone measure)**

**Reasons/rationale for selecting the outcome measure:**

Local, state, and national data for Medicaid recipients and the uninsured are unequivocal in showing the lack of access to care and subsequent coordination of care for these populations. RHP 6 presents a challenge in this regard as funding sources for performing providers is uneven at best and the disparities in primary care and specialty resources are very apparent. The telemedicine project proposed here will help address these issues by providing quality health
care in a cost-effective manner. Engaging a patient face-to-face through technology offers the opportunity for education and inquiry into an individual’s management of his/her diabetes. Given the health care disparities among and within the RHP 6 counties, including the prevalence of diabetes, the opportunity to interact with hard-to-reach patients will advance access, enhance management of the chronic condition, and contribute to a reduction in hospital admissions.

**Relationship to other Projects:**

This project supports multiple projects and interventions of the Health System’s DSRIP program. Establishing a presence in telemedicine throughout the region will assist in the expansion of access to primary and specialty care. In addition to that, this project will provide a significant resource to managing our populations by linking this resource with care coordination and other service lines that can contribute to improved outcomes.

Related projects:
92414401.2.2 – Enhance/expand the medical homes
Telehealth will expand the medical home concept by offering services that would otherwise be unavailable. These services include, but are not limited to, telemedicine, tele-case management, and tele-patient education.

136141205.2.7 – Implement evidence-based disease prevention programs
Education offered individually or in group visits will be evidence-based.

136141205.2.2 – Redesign to improve patient experience
Research has proven that patient satisfaction will increase as a result of the implementation of a Care Management Model which is enhanced by telemedicine and telehealth. The expectation will also be improved provider satisfaction within our ambulatory clinics. A recent study completed with the Affinity Health System showed an increase in provider satisfaction and patient compliance.

136141205.2.4 – Establish/expand a patient care navigation program
Telemedicine/Telehealth can support care management model through patient access to navigation. This allows patient access throughout the health care continuum while simultaneously addressing chronic conditions identified by the patient’s provider.

Category 4 measures include potentially preventable admissions in RD-1 and patient-centered health care, including patient satisfaction and medication management in RD-4.

**Relationship to Other Performing Providers’ Projects in the RHP:**

1.7.1: Introduce, Expand, or Enhance Telemedicine/Telehealth

094154402.1.1 – Methodist Hospital (Pass 1)
085144601.1.15 – UTHSCSA (Pass 2):

UTHSCSA is the Health System’s partner in delivering care to the county’s Medicaid and currently uninsured populations. We will attempt to collaborate with the medical school and Methodist Hospital on their projects, share lessons learned and best practices about telemedicine, and support a learning collaborative should one be formed on this topic.
Plan for Learning Collaborative:

This project naturally lends itself to participation in learning collaboratives as other Performing Providers seek to employ telemedicine/telehealth to increase access to primary and specialty care, erase disparities in care, and reduce ED utilization in other parts of the region. We will attend meetings and share data related to the efficacy of this project.

Project Valuation:

1. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce hospital admissions (containing cost growth).

2. This project addresses community needs by improving access to care for populations with a high prevalence of chronic conditions and reducing disparities in care by allowing access to primary, and particularly specialty, care providers which may be in short supply. A significant impact on health outcomes and utilization costs stands to be gained. As noted earlier, diabetes was identified by the Texas HHSC as a condition for which potentially preventable hospitalizations and readmissions were observed.

3. When fully implemented – beyond DY5 – which includes telemedicine initiatives for other highly prevalent chronic conditions, such as CHF, as well as eventually sharing the technology among the region’s Performing Providers, the larger scope of the project will impact outreach efforts to both physicians and their Medicaid and uninsured patients; will improve proper utilization in the form of increased routine and follow-up patient visits and encounters; will attract and retain physicians in the Health System; and will promote savings through appropriate ED utilization.

4. This project requires a very large investment as it fits with HITECH funding goals. The hardware, software applications, human resources, and time to implement are of the highest organizational priority for the Health System. This particular project targets diabetes, but the scope of utilization for other chronic diseases and in other health care settings is potentially huge.
<table>
<thead>
<tr>
<th>136141205.1.4 PASS 1</th>
<th>1.7.1</th>
<th>1.7.1 (A-B)</th>
<th><strong>1.7.1 IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION: UNIVERSITY HOSPITAL TELEMEDICINE PROGRAM</strong></th>
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<td>University Hospital</td>
<td>TPI - 136141205</td>
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| Related Category 3 Outcome Measure(s): | 136141205.3.6 | 3.1T-2.8 | Diabetes Long Term Complications Admission Rate – PQI3 (Standalone measure) |

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 4</strong></td>
<td><strong>Milestone 6</strong></td>
<td><strong>Milestone 8</strong></td>
</tr>
<tr>
<td>[P-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine as related to Diabetes</td>
<td>[P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need</td>
<td>[I-12]: Increase number of telemedicine visits for each specialty identified as high need.</td>
<td>[P-4]: Implement or expand telemedicine program for targeted health services, based upon regional and local community need</td>
</tr>
<tr>
<td>Metric 1 [P-1.1]: Needs assessment to identify types of personnel needed to implement the program and hiring of the respective personnel. Baseline: N/A Goal: Submission of completed needs assessment Data Source: Needs assessment</td>
<td>Metric 1 [P-3.1]: Documentation of diabetes program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline: N/A Goal: Submission of implementation documentation Data Source: Program materials</td>
<td>Metric 1 [I-12.1]: Number of adult diabetes telemedicine visits. Numerator: Number of visits in which patients are seen using telemedicine services for diabetes subspecialty provided by specified time frame and geographic area in a RHP or for individual provider. Denominator: Number of patients referred to designated specialists Baseline: 14 patients/month of service (1%) Goal: 100 patients/month (10%) of patients referred to</td>
<td>Metric 1 [P-4.3]: Pre- and post-evaluations completed by remote health care providers demonstrating they gained knowledge and capacity on key areas of specialty knowledge. Provide specific survey to test the knowledge accumulated through the tele-service. Baseline: 0% Goal: 20% over baseline Data Source: Results of the pre and post tele-service survey</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,336,103.66</td>
<td>Milestone 4 Estimated Incentive Payment: $2,186,426</td>
<td>Milestone 6 Estimated Incentive Payment:</td>
<td>Milestone 8 Estimated Incentive Payment:</td>
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<th>Description</th>
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<th>Metric 2</th>
<th>Metric 3</th>
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<tr>
<td>[P-2]:</td>
<td>Conduct needs assessment to identify needed specialties that can be provided via telemedicine beyond target of diabetes for future expansion</td>
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<tr>
<td>[P-2.1]:</td>
<td>Needs assessment.</td>
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<td>Baseline:</td>
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<td>Goal: Submission of completed needs assessment</td>
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<td>Data Source: Needs assessment</td>
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<tr>
<td>[P-X]:</td>
<td>Complete planning process to implement telemedicine in three designated Health System clinics</td>
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<tr>
<td>[P-X.1]:</td>
<td>Project Plan</td>
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<td></td>
<td>Baseline:</td>
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<td></td>
<td>Goal: Submission of project plan</td>
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<td></td>
<td>Data Source: Needs Assessment and Project Plan</td>
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<td>Milestone 3</td>
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<tr>
<td>Milestone 5</td>
<td>Upgrade or improve technology to support the project</td>
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<tr>
<td>Metric 1</td>
<td>Evaluation of technology implemented against industry evidence-based best practices</td>
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<tr>
<td>Metric 2</td>
<td>Pre- and post-evaluations completed by remote health care providers demonstrating they gained knowledge and capacity on key areas of specialty knowledge. Provide specific survey to test the knowledge accumulated through the tele-service.</td>
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<td>Milestone 6</td>
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<tr>
<td>Milestone 7</td>
<td>Implement or expand telemedicine program for targeted health services, based upon regional and local community need. Hire full-time endocrinologist.</td>
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<tr>
<td>Metric 3</td>
<td>Pre- and post-evaluations completed by remote health care providers demonstrating they gained knowledge and capacity on key areas of specialty knowledge. Provide specific survey to test the knowledge accumulated through the tele-service.</td>
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<tr>
<td>Metric 4</td>
<td>Pre- and post-evaluations completed by remote health care providers demonstrating they gained knowledge and capacity on key areas of specialty knowledge. Provide specific survey to test the knowledge accumulated through the tele-service.</td>
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<tr>
<td>Milestone 8</td>
<td>Estimated Incentive Payment: $2,192,782</td>
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<tr>
<td>Milestone 9</td>
<td>Expand telemedicine program to additional clinics</td>
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<tr>
<td>Metric 5</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<tr>
<td>Metric 6</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<td>Metric 7</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<td>Metric 8</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<td>Metric 9</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<td>Metric 10</td>
<td>New telemedicine-enhanced clinics Numerator: Number of clinics providing at least 40 telemedicine visits per month. (200 visits/month total between all the clinics)</td>
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<td>Milestone 11</td>
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Incentive Payment: $1,811,428.50
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<th>Year 2 Estimated Milestone Bundle Amount:</th>
<th>Year 3 Estimated Milestone Bundle Amount:</th>
<th>Year 4 Estimated Milestone Bundle Amount:</th>
<th>Year 5 Estimated Milestone Bundle Amount:</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $16,389,584
Identifying Project and Provider Information:

Title: 1.9.2 Expand Access to Specialty Care (Behavioral Health)
Unique RHP ID#: 136141205.1.5 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:

Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): This project will increase access to behavioral health specialty care by adding/increasing behavioral health providers at primary care clinics and having patients receive behavioral health services through integrated patient-centered medical home/neighborhood clinics (PCMH). The PCMH is an innovative, evidence-based program to improve primary care. Adding behavioral health capacity in this infrastructure will provide seamless referrals and increase access to specialty care.

Need for the project: According to the Bexar County Health Status Report Based on Behavioral Risk Factor Surveillance (BRFSS) Data Collected in 2008, 33% of survey respondents said their mental health was not good for one or more days over the past month and 18% reported five or more days of poor mental health. Depression, drug and alcohol use, and lack of access to mental health services were cited as the most frequent mental health issues. Some respondents shared that mental health care is difficult to acquire due to a lack of insurance coverage.

Respondents also mentioned that many Bexar residents do not access care at all because they do not know what mental health services are available. Lack of awareness of services and social stigma around mental health disorders were two major challenges in this area. Education campaigns were suggested as a way to inform Bexar residents about the available mental health services in the community.

Target population: The target population will be those who receive primary care services within University Health System primary care clinics, and who fall into either Quadrant I or III regarding behavioral health needs. Medicaid-funded (19%) and uninsured (43%) persons represent 62% of the patient population served by the Health System. (Ref. for Quadrant Model: National Council for Community Behavioral Healthcare, 2003). These patients will benefit from increased access to behavioral health services in the primary care setting.

Category 1 or 2 expected patient benefits: The Health System will improve access for behavioral health services by demonstrating an increase in volume of services provided in DY2 through DY5:

- **DY2** – Increase behavioral health patient encounters by 2% over baseline; 12,186 expected behavioral health encounters.
- **DY3** – Increase behavioral health patient encounters by 4% over baseline; 12,425
expected behavioral health encounters.

- **DY4** – Increase behavioral health patient encounters by 6% over baseline; 12,664 expected behavioral health encounters.
- **DY5** – Increase behavioral health patient encounters by 8% over baseline; 12,903 expected behavioral health encounters.

**Category 3 outcomes:** IT-1.18 – The goal is to increase access to follow up appointments post discharge for mental illness.

- **DY4** – Increase by TBD% over baseline the number of patients securing outpatient mental health appointments within 7 days and within 30 days post discharge.
- **DY5** – Increase by TBD% over baseline the number of patients securing outpatient mental health appointments within 7 days and within 30 days post discharge.

**Project Description:**

In the United States, safety-net hospitals remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. The passage of the Affordable Care Act in 2010 marked an important legislative commitment to addressing rising health care costs and improved access to quality healthcare for all Americans. In the era of healthcare reform, safety-net hospitals will therefore remain critical to responding to the mandate of providing primary and specialty medical care that is accessible, integrated, and patient-centered.

University Hospital proposes to increase access to specialty care by expanding its provider base and having patients receive behavioral health services through its integrated patient-centered medical home (PCMH). The PCMH is an innovative, evidence-based program to improve primary care. Adding behavioral health capacity in this infrastructure will provide seamless referrals and increase access to specialty care.

This project will increase access to behavioral health within the University Health System medical homes which will be accomplished by adding behavioral health providers (which may include psychiatrists, psychiatric nurse practitioners, psychologists, behavioral therapists, and/or licensed chemical dependency counselors, as determined by demand) to these settings and thereby leading to increased accessibility. The target population will be those that receive primary care services within University Health System primary care clinics, and who fall into Quadrant I or III regarding behavioral health needs—typically those most likely to be appropriately cared for in primary care settings with co-located behavioral health practitioners. (Ref. for Quadrant Model: National Council for Community Behavioral Healthcare, 2003).

Texas currently ranks 50th in per capita state funding for behavioral health treatment, and persons in RHP 6 experience barriers to accessing behavioral health care. In addition, Bexar County ranks in the top 10 in Texas in terms of least funded Local Mental Health Authorities. Funding for clinical care is restricted to certain mental illness diagnoses, leaving a large segment of persons with a mental illness (including those most commonly seen in primary care settings) without access to appropriate care and treatment.

Community Medicine Associates (the University Health System owned provider group) is the primary care access point for University Health System patients, and there is currently a need for...
behavioral health specialty providers for the population served to enhance the medical home model and expand behavioral health care to additional sites.

Goals and Relationship to Regional Goals
Project goals are to expand access to behavioral healthcare within the primary care setting and thereby address the regional goals of filling gaps in access to behavioral health for economically underserved populations.

Project Goals:
- Increase the number of behavioral health providers.
- Increase the percentage of patient-centered behavioral health specialty visits
- Improve accessibility to appointments post-hospital discharge in target population.

Challenges
A primary challenge will be recruiting and retaining psychiatric providers since Texas currently has a workforce shortage of psychiatrists. For example, based on the national ratio of 13.9 psychiatrists/100,000 population, San Antonio needs an additional 49 psychiatrists to provide care. If based on the University of Texas Medical Branch recommendations of 25.9 psychiatrists/100,000 population, San Antonio needs an additional 294 psychiatrists. (Ref: Methodist Health Care Ministries Mental Health Services Project, San Antonio, July 2010). Recruiting and retention challenges will be overcome by designation of Health Provider Shortage Areas (HPSAs) as designated by HRSA of some primary care clinic sites as underserved areas as relates to behavioral healthcare which then allow Medicare designated bonus payments.

5-Year Expected Outcome for Provider and Patient
University Health System expects to have improved access to specialty care alongside an expanded provider base and a percentage increase in patients receiving behavioral health services through its integrated patient-centered medical home. The result of these efforts will be both an improvement in follow-up post hospitalization for a mental illness diagnosis and reduce emergency room visitation for preventable conditions.

Starting Point/Baseline:
Currently there is one FTE psychiatrist, one FTE psychiatric nurse practitioner, and five FTE therapists who provide specialty behavioral health services at one clinical location. During the baseline year ending September 30th, 2012 (DY1), the University Health System’s owned primary care clinic sites had 11,947 behavioral health provider encounters.

Rationale:
Currently, the demand for behavioral health treatment of patients with behavioral health needs primarily in the areas of the city that have been identified as economically underserved (low behavioral health co-morbid with low to high physical health needs) within the community has outstripped available outpatient resources. For example hospitalization data for mental illness is more pronounced in the southern and western sectors of the County and is considered a direct result of having limited clinical care and treatment resources.
Further, state funding for mental health treatment is restricted to certain mental health diagnoses, thus excluding a large percentage of persons with other mental illnesses, e.g., anxiety disorders, mild to moderate depressive disorders, attention-deficit/hyperactivity disorder, bereavement, adjustment reactions, etc. Focusing on Quadrant I and III includes those diagnoses most likely to be encountered in the primary care setting.

Population forecasts for the Bexar County primary service area predict an increase by 9% in the demand for behavioral health services by 2019, including the need for pharmacologic management. (Ref: Methodist Health Care Ministries Mental Health Services Project, San Antonio, July 2010).

The cost benefit of providing integrated care for treating common mental health disorders is similar to the benefit achieved in treating other chronic conditions (Ref: Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States, Hogg Foundation for Mental Health). This project is selected to enhance integration of behavioral health care for those patients served by University Health System’s patient-centered medical home. It addresses the need for specialty behavioral health services for those patients who cannot access services because of diagnostic restrictions, lack of funding, or lack of access to behavioral health providers accepting Medicaid and/or Medicare.

Patients, particularly those in ethnic minority groups, often do not adhere to their primary care provider’s referral to specialty mental health care. (Ref: Takeuchi DT & Cheung MK: Coercive and Voluntary Referrals: How Ethnic Minority Adults Get Into Mental Health Treatment. Ethnicity and Health, 3, 149 – 153.)

Additionally, in Texas, RHP 6, and San Antonio/Bexar County, primary care providers are often unable to locate mental health providers and/or psychiatrists to refer patients leading to disparate care and further exacerbating the health inequalities among these vulnerable populations. Screening for mental health disorders leads to improved patient outcomes only when appropriate care follows detection. (Ref: Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States, Hogg Foundation for Mental Health).

Patients with mental illness at times require assessment by a behavioral health provider in order to unburden primary care providers of disease acuity requiring specialty consultation, to improve the comfort level of primary care providers in managing co-morbid behavioral health conditions, and to improve the overall quality of life of patients by addressing the patient’s needs holistically and in a manner that is coordinated.

This project addresses community health need CN.4 – Address the shortage of high quality integrated mental and behavioral health services in the community.

In terms of system redesign, this project represents an initiative to integrate behavioral health treatment for patients served by University Health System’s patient-centered medical home by providing care in the right setting and at the right time for patients who historically have been unable to access outpatient behavioral health care, by providing earlier detection and treatment and potential cost avoidance of unnecessary hospitalizations and/or ER visits due to preventable conditions that include appropriate and timely treatment mental illness, coordinated outpatient post-discharge follow-up.
This project addresses the following Core Components:

a) Increase service availability with extended hours: University Health System anticipates expanding clinic hours during the project, after determining when and where the additional hours would be beneficial.

b) Increase number of specialty clinic locations: University Health System anticipates adding behavioral health care at additional community clinic sites in DY2, which is reflected in milestone 1.

c) Implement transparent, standardized referrals across the system: University Health System has already implemented this component and does not need to further address at this time.

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. University Health System anticipates addressing access to services by those patients falling out of the target population or addressing care transition with high risk for hospitalization patients. University Health System also anticipates engaging in face-to-face biannual meetings with other providers and the RHP to

Related Category 3 Outcome Measure(s):

IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)

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

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

b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

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

d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

Rate 1. The percentage of members who received follow-up within 30 days of discharge
Rate 2. The percentage of members who received follow-up within 7 days of discharge.

Reasons/Rationale for selecting the outcome measures:
The selection of this outcome measure underscores the importance of addressing the triple aim in healthcare which includes improving quality of care, improving population health in a cost-effective manner. Additional milestones and metrics were selected to reflect an increase in behavioral health providers and their integration within additional primary care sites.

**Relationship to other Projects:**
The project focuses on behavioral health expansion and integration into the medical home also fully supports related DSRIP projects that target disease management, expansion of primary care capacity and redesign of patient experience.

(Project ID: 136141205.1.2) Expand Primary Care Capacity: Expanding and integrating behavioral health care within the medical home will improve the training of the primary care workforce through side-by-side modeling and case discussion.

(Project ID: 136141205.1.3) Implement a Chronic Disease Management Registry: Management of certain chronic behavioral health disorders within medical homes will be supported by the disease management registry so that identification of gaps in care and enhance behavioral health service line planning.

(Project ID: 136141205.1.7) Enhance/Expand Medical Homes: Expansion and integration of behavioral health providers within the medical home allows for the provision of care with the patient at the right time and in the right setting and for managing co-morbid mental health and physical conditions in a coordinated, holistic way.

(Project ID: 92414401.2.1) Expand Chronic Care Management Models: Interventions aimed at managing certain chronic mental health disorders commonly seen in primary care settings, are aimed at improving health outcomes and quality of care, potentially helping to reduce unnecessary hospitalizations and ER visits.

(Project ID: 136141205.2.2) Redesign to Improve Patient Experience: By providing increased access to specialized mental health care within the medical home in a coordinated way, patient-centered care is enhanced by improving timely access to specialists and improving the patient’s overall health and functional status.

(Project ID: 136141205.2.4) Establish/Expand a Patient Care Navigation Program: Expanding behavioral health care in the medical home will enhance the opportunity for care navigation to
appropriate care in the right setting to patients vulnerable to admission and readmission to inpatient settings.

(Project ID: 136141205.2.1) Implement/Expand Care Transitions Programs: Access to outpatient appointments for those discharged from the hospital will improve care transition by providing care a continuum of care within University Health System.

Category 4
RD-1. Potentially Preventable Admissions: Expansion of and access to outpatient behavioral health services for those patients served in University Health System medical homes who have co-morbid physical illnesses in one of the potentially preventable admission diagnoses will help alleviate the contribution of untreated behavioral health diagnoses to instability of the physical diagnosis leading to admission.

RD-2. 30-Day Readmissions: Expansion of and access to outpatient behavioral health services for those patients served in University Health System medical homes with certain behavioral health diagnosis will help prevent 30-day readmissions.

Relationship to Other Performing Providers’ Projects in the RHP:
92414401.1.1 Expand training of the primary care workforce
Training future providers in primary will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

Plan for Learning Collaborative:
This project lends itself to participation in learning collaboratives as other Performing Providers in RHP6 seek to develop or enhance behavioral health services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve primary care access.

Project Valuation:
Project valuation for enhancing access to behavioral health services directly responds to waiver goals including the triple aim and improving the health delivery infrastructure to better serve the Medicaid and uninsured residents of the community and region. This includes providing care in the right setting at the right time and enhancing the ability to treat mental health disorders earlier in the course of illness, both of which may contribute to avoidance of unnecessary admissions and ER visits that might be due to untreated mental illness. The project also addresses community need by responding to gaps in delivery of behavioral health services. The Bexar County Mental Health Consortium, a broad representation of mental health agency stakeholders, has identified access to outpatient mental health care as a major need in the community, including enhancing availability of these services within the medical home. Additionally, treatment of chronic mental illnesses shows improved outcomes just as those seen with treatment of chronic physical illnesses, and coordinated care of co-morbid behavioral and physical illness diagnoses in an integrated fashion tends to improve outcomes of both. The project is considered large in scope as it looks to increase outreach to the targeted population and thereby increase the number of patients with behavioral health needs thereby reducing cost and avoidable
hospitalizations. Relative to other projects, the proposed efforts are large in scale and will require investment in human resources, technology and organizational priorities that strengthen the opportunity to deliver integrated and accessible care to the target population.
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<tr>
<th>136141205.1.5 PASS 1</th>
<th>1.9.2</th>
<th>A-D</th>
<th>1.9.2 Expand Access to Specialty Care (Behavioral Health)</th>
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<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.7</td>
<td>IT-1.18</td>
<td>Follow-Up After Hospitalization for Mental Illness – NQF 0576 (Standalone measure)</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 1</strong> (P-11): Expand /launch specialty care clinic (psychiatry)</td>
<td><strong>Milestone 3</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
<td><strong>Milestone 4</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
<td><strong>Milestone 6</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
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<td>Metric 1 (P-11.1a): Number of patients served by specialty care clinic. Goal: Expand number of specialty care units (psychiatry) Data Source: Documentation of increased number of patients served by specialty clinic, IDX, EMR and OP activity reports</td>
<td>Metric (I-23.1): Documentation of increased number of visits. Baseline: 11,947 behavioral health encounters in baseline year ending September 30th, 2012 Goal: Increase number of behavioral health encounters by 4% over baseline (12,425 expected encounters) Data Source: IDX, EMR and OP activity reports</td>
<td>Metric (I-23.1): Documentation of increased number of visits. Baseline: 11,947 behavioral health encounters in baseline year ending September 30th, 2012 Goal: Increase number of behavioral health encounters by 6% over baseline (12,664 expected encounters) Data Source: IDX, EMR and OP activity reports</td>
<td>Metric (I-23.1): Documentation of increased number of visits. Baseline: 11,947 behavioral health encounters in baseline year ending September 30th, 2012 Goal: Increase number of behavioral health encounters by 8% over baseline (12,903 expected encounters) Data Source: IDX, EMR and OP activity reports</td>
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<td>Milestone 1 Estimated Incentive Payment: $2,357,830</td>
<td>Milestone 3 Estimated Incentive Payment: $5,144,532</td>
<td>Milestone 4 Estimated Incentive Payment: $2,579,743.50</td>
<td>Milestone 6 Estimated Incentive Payment: $2,131,092.50</td>
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<td><strong>Milestone 2</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
<td><strong>Milestone 5</strong></td>
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<td>Metric 1 (I-23.1):</td>
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<td>Milestone 3 Estimated Incentive Payment: $5,144,532</td>
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<td>Milestone 7</td>
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<td>Documentation of increased number of visits. Baseline: 11,947 behavioral health encounters in baseline year ending September 30th, 2012 Goal: Increase number of behavioral health encounters by 2% over baseline (12,186 encounters) Data Source: IDX, EMR and OP activity reports Milestone 2 Estimated Incentive Payment: $2,357,830</td>
<td>(P-21) Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric: (P-21.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $2,579,743.50</td>
<td>(P-21) Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric: (P-21.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $2,131,092.50</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $4,715,660</td>
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Identifying Project and Provider Information:
Title: 1.3 Expand school–based/mobile health clinics
Unique RHP ID#: 136141205
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): The Health System will expand primary care access through development and implementation of a school-based health center/mobile clinic based program to link children and adolescents of Bexar County, Texas with clinical preventive care. This project will expand primary care access by developing and implementing school-based health centers alongside mobile screenings in order to more effectively link students with clinical preventive care services. This will occur by establishing school-based health centers at or near a school campus, and/or having a mobile health clinic visit the school and/or provide these services by having students transported to a regional medical home located with the Health System ambulatory network of care to receive preventive screenings and immunizations.

Need for the project: Studies find that economically vulnerable populations including minority children are much less likely to have access to timely and appropriate health care. The rate of uninsured in Bexar County is 23% highlighting the need for increased access. In addition, access to timely clinical preventive screenings can prevent and detect illnesses and diseases in their earlier, more treatable stages, which can lead to reduced risk of illness, disability, early death, and medical care costs.

Target population: Economically vulnerable children and adolescents in need of evidence-based clinical preventive screening and primary care access that reside within the Health System service area.

Category 1 or 2 expected patient benefits: The anticipated 5 year goal is to establish three fully-operational school-based/mobile heath clinics programs to expand delivery of preventive care to underserved populations. The secondary goal is to support coordination of services that improve timely access to related United States Preventive Services Task Force (USPTF) preventive screenings that include obesity in children, adolescents, visual and hearing, lead levels and behavioral health that has demonstrated to reduce risk of illness, disability, early death, medical care costs.

Category 3 outcomes:
- IT-12.5 Other USPSTF-endorsed screening outcome measures (screening for obesity in
children and adolescents)

- IT-12.5 Other USPSTF-endorsed screening outcome measures (screening of adolescents 12-18 years of age) for major depressive disorder (MDD)

- IT-12.5 Other USPSTF-endorsed screening outcome measures (immunizations, adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) using American Academy of Family Physicians (AAFP) recommendations unless contraindicated

**DY4** –
- TBD Percent improvement over baseline of number of children and adolescents screened for obesity
- TBD Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)
- TBD Percent improvement over baseline of number of adolescents 13-18 that receive the Meningococcal Conjugate Vaccine (MCV-1)

**DY5** –
- TBD Percent improvement over baseline of number of children and adolescents screened for obesity
- TBD Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)
- TBD Percent improvement over baseline of number of adolescents 13-18 that receive the Meningococcal Conjugate Vaccine (MCV-1)

**Project Description:**

The project’s goal of implementing evidence-based strategies that expand primary care access firmly coincide with national and regional goals that include the National Prevention Strategy’s efforts to link populations with clinical preventive care. These goals aim to improve delivery of high quality evidence-based clinical preventive services to special populations that consist of screening and immunizations that can prevent diseases and reduce mortality associated with chronic disease and can encourage healthy behavior from a very young age.

Delivery of evidence-based clinical, community preventive services (i.e., immunizations, screenings), and the integration of these activities within a school-based setting are central to improving and enhancing the health status of children and adolescents of Bexar County, Texas. Establishment of a school-based clinic can support implementation of community-based preventive services and enhance linkages with clinical care as well as reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.

Community Medicine Associates, the provider network for University Hospital, will partner with the University of Texas Health Science Center at San Antonio and local school districts to establish a model of care that is accessible, coordinated, comprehensive and patient-centered for
students. The primary emphasis will be placed on expanding health care services within major urban school districts such as the San Antonio Independent School District which has a current enrollment of 54,000 students of which more than eight out ten (86%) are economically disadvantaged. This will occur by leveraging resources with community-based educational service providers (i.e., Headstart, San Antonio ISD, Edgewood ISD among others) alongside accessibility to a mobile health and wellness unit that will provide timely access to school-based immunization and screening services. Provision of clinical preventive services will be made possible via a mobile health and wellness program alongside the establishment of a free standing school-based health clinic in areas that encompass both a large student population and that remains medically underserved. Clinical preventive menu of screening and related health services will include: physicals, primary care, immunizations, Texas Health Steps, health education, minor illness, and referrals to specialty.

Relationship to Regional Goals:
This project will further the achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth. Specifically, this project will expand a mobile health clinic within major urban school districts. Creating a clinical linkage and establishing a usual source of care through a school-based/mobile health program center can strengthen adherence to preventive care and healthy decision-making thus translating into lives saved and cost-savings to both the healthcare delivery system and the local community.

The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the establishment of an appropriate Learning Collaborative.

Five year expected outcomes for provider and patient: University Hospital expects to have a series of fully established school-based/mobile health centers tailored to meeting the health services needs of children and adolescents and their caregivers enrolled in major urban school districts within Bexar County, Texas. Further, implementation and expansion of these school-based clinics primarily leveraged through the existing network of University Health System preventive health clinics will directly maximize the opportunity to improve delivery of high quality evidence-based clinical preventive services to special populations. These will consist of screenings and immunizations that can prevent disease and reduce mortality associated with chronic conditions and that encourage healthy behavior from a very young age.

Ultimately, by the end of DY5, data will demonstrate the proportion of the target population that received age and sex appropriate clinical preventive care including screening for obesity in children and adolescents, screening for major depressive disorders in adolescents and delivery of the meningococcal conjugate vaccine to adolescents are defined as the primary health outcomes of interest (Primary Care and Primary Prevention OD-12). This will occur by ensuring that process and improvement milestones are met throughout the life of the project.
Starting Point/Baseline:
Based on the current community outreach model the starting point/baseline is 0

Rationale:
Adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability is in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from the flu to cancer that if caught in their earlier, more treatable stages, can significantly reducing the risk of illness, disability, early death, and health care costs. For example, on average, 42,000 deaths per year are prevented among children who receive recommended childhood vaccines. Yet, despite this evidence and such services are now covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act (ACA), large segments of the U.S. population which translate into millions of children, adolescents, and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.

This project specifically addresses community need three (CN.3):

CN.3 – Address the lack of medical and dental health services in the community due to high rates of uninsurance and provider shortages. The current project is a system redesign that enhances the current delivery of care model by leveraging the network of University Health System Preventive Health Clinics in the community. Specifically, these preventive health clinics will help to establish a usual source of care in the population through integration and maintenance that is accessible, coordinated, comprehensive and patient-centered for children and adolescents that attend school within the district. These efforts will therefore serve to reduce health inequities that address the triple aim of providing high quality care, improving population health and reducing the per capita cost of health care; University Hospital will engage in population-based interventions that are coordinated, comprehensive and multi-component to more effectively address the health needs of the 1.7 million residents of this major urban Texas region. With particular emphasis placed on the adolescent population, this will occur by implementing evidence-based strategies that encourage healthy lifestyles through delivery of clinical preventive services. Such efforts will also coincide with Healthy People 2020, The National Prevention Council’s National Prevention Strategy to engage and empower individuals, promote healthy and safe communities and align with clinical and community preventive services to reduce disparities in health.

Related Category 3 Outcome Measure(s):

OD – 12 Primary Care and Primary Prevention:

IT-12.5 Other USPTF-endorsed screening outcome measures (Screening for obesity in children and adolescents)

Rational/Evidence: Since the 1970s, childhood and adolescent obesity has increased three to six-fold. Approximately 12% to 18% of 2- to 19-year-old children and adolescents are obese (defined as having an age- and gender-specific BMI at ≥95th percentile). The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or
refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. The USPSTF found that effective comprehensive weight-management programs incorporated counseling and other interventions that targeted diet and physical activity. Interventions also included behavioral management techniques to assist in behavior change. Interventions that focused on younger children incorporated parental involvement as a component.

Moderate- to high-intensity programs involved >25 hours of contact with the child and/or the family over a 6-month period and showed results including improved weight status, defined as an absolute and/or relative decrease in the BMI 12 months after the beginning of the intervention. Most participants were obese, and it is not known whether these results can be applied to children who are overweight but not obese. In addition, evidence was limited on the long-term sustainability of BMI changes achieved through behavioral interventions and on the trajectory of weight gain in children and adolescents. Interventions generally took place in referral settings, and the results can only be generalized to children who follow through on treatment. Low-intensity interventions, defined as ≤25 contact hours over a 6-month period, did not result in significant improvement in weight status.

**Numerator:** Number of children ages 6 years and older screened and referred to comprehensive behavioral interventions to promote weight status.

**Denominator:** Number of children ages 6 and older from the target population.

**Data Source:** EHR, Claims

**IT – 12.5 Other USPSTF-endorsed screening outcome measures** screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

**Rationale/Evidence:** Depression among youth is a relatively common, disabling condition that is associated with serious long-term morbidities and risk of suicide. The majority of depressed youth, however, are undiagnosed and untreated, despite opportunities for identification in settings such as primary care. A synthesis of the evidence suggest that primary care screening tools may be accurate in identifying depressed adolescents, and treatment can improve depression outcomes. Specific treatment should be based on the individual's needs and mental health treatment guidelines (USPSTF, Systematic Review, 2009).

**Numerator:** Number of adolescents ages 12 to 18 years screened for major depressive disorder.

**Denominator:** Number of adolescents ages 12 to 18 from the target population.

**Data Source:** EHR, Claims

**IT – 12.5 Other USPSTF-endorsed screening outcome measures** Immunizations, Adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) using American Academy of Family Physicians (AAFP) recommendations unless contraindicated

**Rationale/Evidence:** Adherence to clinical preventive services, such as routine disease
screening and scheduled immunizations, are key to reducing death and disability is in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from the flu to cancer that if caught in their earlier, more treatable stages, can significantly reduce the risk of illness, disability, early death, and health care costs. For example, on average, 42,000 deaths per year are prevented among children who receive recommended childhood vaccines.

Numerator: Number of adolescents ages 13 to 18 years that receive the meningococcal conjugate vaccine (MCV-1).

Denominator: Number of adolescents ages 13 to 18 from the target population.

Data Source: EHR, Claims

**Relationship to other Projects:**

This project’s focus on enhancing a mobile clinic to allow school age children access to primary and preventive services ties to these Category 1 and Category 2 projects in our RHP:

**Category 1**

(Project ID: 136141205.1.1) **Expand Primary Care Capacity**: Expanding and integrating psychiatric care within the medical home will improve the training of the primary care workforce through side-by-side modeling and case discussion.

**Category 2**

(Project ID: 92414401.2.2) **Enhance/Expand Medical Homes**: Expansion and integration of psychiatric providers within the medical home allows for the provision of care with the patient at the right time and in the right setting and for managing co-morbid mental health and physical conditions in a coordinated, holistic way.

(Project ID: 136141205.2.2) **Redesign to Improve Patient Experience**: By providing increased access to specialized mental health care within the medical home in a coordinated way, patient-centered care is enhanced by improving timely access to specialists and improving the patient’s overall health and functional status.

Related Category 4 measures include RD-1. Potentially Preventable Admissions.

8. **Influenza Immunization**

   Influenza Immunization (CMS IQR/Joint Commission measure IMM-2)

**Relationship to Other Performing Providers’ Projects in the RHP:**

**Plan for Learning Collaborative:**

University Health System is very interested in sharing best practices, lessons learned, and other ideas to expand mobile clinics. We will participate in face-to-face meetings and/or conference calls to regularly share data related to the efficacy of various practices along with lessons learned as we implement this program.
### Project Valuation:

1. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

2. This project addresses community needs by improving quality of healthcare delivery and patient experience, enhancing access to health services and expanding prevention efforts.

3. The large scope of the project that includes expansion across the 14 school districts in Bexar County, Texas is critical to ensuring a healthy population (children, adolescents, caregivers and the surrounding areas).

4. This project requires a very large investment in terms of personnel, technology and infrastructure to ensure a coordinated approach to clinical preventive care is taken across the various major urban school districts. The hardware, software applications, human resources and time elements required to implement this project are of the highest organizational priority for University Health System. This particular project targets the adolescent population, but the scope is also expansive in that it addresses both the current and future health needs of the population.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>University Hospital</th>
<th>TPI - 136141205</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.3</td>
<td>N/A</td>
<td>1.1.3 Expand school–based/mobile health clinics</td>
<td></td>
</tr>
</tbody>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</table>

**Milestone 1**
[P-2] Implement a school-based clinic program

**Metric 1** [P-2.1.] Number of additional clinics or expanded hours

**Baseline/Goal:**
Baseline: October 1, 2011 to September 30, 2012 (0)

Goal: One (1) fully operational school-based health center/mobile-health program in one (1) major urban school district.

Data Source: New primary care schedule or other performing provider documents, fully executed agreements with school districts

Milestone 1 Estimated Incentive

**Milestone 2**
[P-2] Implement a school-based/mobile clinic program

**Metric 1** [P-2.1.] Number of additional clinics or expanded hours

**Baseline/Goal:**
Baseline: October 1, 2011 to September 30, 2012 (0)

Goal: One (1) fully operational school-based health center/mobile-health program in one (1) major urban school district

Data Source: New primary care schedule or other performing provider documents, fully executed agreements with school districts

**Milestone 4**
[P-2] Implement a school-based/mobile health clinic program

**Metric 1** [P-2.1.] Number of additional clinics or expanded hours

**Baseline/Goal:**
Baseline: October 1, 2011 to September 30, 2012 (0)

Goal: One (1) fully operational school-based health center/mobile-health program in one (1) major urban school district

Data Source: New primary care schedule or other performing provider documents, fully executed agreements with school districts to delivery clinical

**Milestone 6**
[1-12] Increase primary care clinic volume visits and evidence of improved access for patients seeking services.

**Metric 1** [I-12.1.]:
Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

**Baseline/Goal:**
Baseline: October 1, 2011 to September 30, 2012 (0)

Goal: Increase of 3,630 visits from DY 2

Data Source: EMR, IDX

Milestone 6 Estimated Incentive Payment: $1,207,619
<table>
<thead>
<tr>
<th>Payment: $4,008,311</th>
<th>Milestone 2 Estimated Incentive Payment: $2,186,426</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment: $2,192,927</strong></td>
</tr>
<tr>
<td>[1-12] Increase primary care clinic volume visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 5</strong></td>
</tr>
<tr>
<td><strong>Metric 2 [I-12.1.]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Baseline: October 1, 2011 to September 30, 2012 DY2 (0) number of patient visits for reporting period. Goal: 3,000 patients visits for reporting period. Data Source: EMR, IDX</td>
<td><strong>Metric 2 [I-12.1.]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Baseline: October 1, 2011 to September 30, 2012 DY2 (0). Goal: Increase to 3,300 visits from DY 2 Data Source: EMR, IDX</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $2,186,426</td>
<td>Milestone 5 Estimated Incentive Payment: $2,192,927</td>
</tr>
<tr>
<td>preventive services</td>
<td><strong>Milestone 7</strong></td>
</tr>
<tr>
<td></td>
<td>P-X: [Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.]</td>
</tr>
<tr>
<td></td>
<td>P-15.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 0 Goal: To conduct two seminars or meetings to promote collaborative learning in a year. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations,</td>
</tr>
</tbody>
</table>
and/or meeting notes.

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance improvement across all providers.

Milestone 7 Estimated Incentive Payment: $1,207,619

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $4,008,311</th>
<th>Year 3 Estimated Milestone Bundle Amount: $4,372,852</th>
<th>Year 4 Estimated Milestone Bundle Amount: $4,385,564</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,415,238</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,389,584</strong></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,389,584</strong></td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,389,584</strong></td>
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</table>
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 1.4.1 Expand Access to Written and Oral Interpretation Services</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 136141205.1.7 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider: University Hospital</td>
</tr>
<tr>
<td>Performing Provider TPI: 136141205</td>
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</tbody>
</table>

### Project Summary:

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** This project will enhance awareness and establish an integrated interpretation service in order to ensure that health information is provided in a manner that is appropriate to a patient’s linguistic and cultural orientation. This will include enhancing awareness of and access to timely oral interpretation services for patients and family members, in order to improve communication and foster understanding between healthcare professionals and their patients/caregivers with limited English language proficiency.

**Need for the project:** Pronounced demographic shifts in the racial and ethnic make-up of the U.S. population illustrate the need for health systems to proactively find ways to deliver high quality care in a manner that is responsive to the cultural beliefs, language and behavior of an ever diverse patient population. According to the U.S. Census, 43% of Bexar County residents speak a language other than English (primarily Spanish) in the home, compared to 34% across the state. The ability of University Health System (UHS) to provide effective care to linguistically diverse populations will be dependent upon staff capacity (skills, knowledge and awareness) to demonstrate culturally competent care. In 2011, vendor-contracted interpreters were called to come to University Health System locations 1,327 times. Through the use of bi-lingual staff members, who have volunteered to interpret in their work areas and successfully completed a comprehensive interpretation course, UHS aims to significantly reduce the need for contracted interpreters for Spanish-speaking patients.

**Target population:** The target population will include the Medicaid funded and uninsured patients who comprise 62% of UHS patients. This will also include the broader UHS service catchment area of Bexar County and South Texas where large segments of the population are economically underserved, uninsured, with a primary language that is other than English.

**Category 1 or 2 expected patient benefits:** This project will conduct a gap analysis to assess gaps in language access and delivery of culturally competent care in DY 2. This will be followed by development and implementation of a 24/7 web-based video interpretation program and staffing capacity in DY 3 and DY 4 resulting in a total of 150 trained volunteer staff interpreters and an established standard document translation process by DY5. This will promote timely oral interpretation/ written translation services, improve exchange of health information and increase patient confidence in adherence to clinical care and treatment.
Category 3 outcomes: 136141205.3.19 IT-6.1 – 3.IT.6.1 Percent improvement over baseline of patient satisfaction scores

- **DY4** – Increase Patient Satisfaction Scores by TBD% over established baseline of patient satisfaction scores.

- **DY5** - Increase Patient Satisfaction Scores by TBD% over established baseline of patient satisfaction scores.

**Project Description:**
Pronounced demographic shifts in the racial and ethnic make-up of the U.S. population illustrate the need for health systems to proactively find ways to deliver high quality care in a manner that is responsive the cultural beliefs, language and behavior of an ever diverse patient population. According to the U.S. Census, 43% of Bexar County residents speak a language other than English (primarily Spanish) in the home, compared to 34% across the state. The ability of University Health System to provide safe, timely, effective and patient-centered care to linguistically diverse populations will be dependent upon staff capacity (skills, knowledge and awareness) to demonstrate cultural competent care, timely availability of qualified healthcare interpreters, and the ability to effectively translate health information between provider and patient in a manner that supports patient adherence to care and treatment.

University Health System therefore proposes to strengthen access to culturally competent patient-centered care through strategies that promote timely oral interpretation/translation services, improve the fluid exchange of health information between patients and healthcare professionals and promote opportunities for patient to adhere to prescribed clinical care and treatment regimens.

**Goals and Relationship to Regional Goals**
Project goals are to enhance awareness of translation services in order to ensure that health information is provided in a manner that is appropriate to a patient’s linguistic and cultural orientation. This will include enhancing awareness of and access to timely oral interpretation services for patients and family members, in order to improve communication and foster understanding between healthcare professionals and their patients/caregivers with limited English language proficiency.

This will also include incorporating strategies that improve the quality of written and oral translation services (English to Spanish) to ensure patients can receive important healthcare information in their preferred language, improve understanding and adherence to instructions, while reducing the cost of outsourcing document translation services. Specific project goals are in line with the project option’s core components (1.4.1, a-d), which therefore are as follows:

**Project Goals**
- Conduct an analysis to determine gaps in linguistic diversity, translation and culturally competent care.
- Train a cadre of volunteers reflective of the gap analysis and assessment to ensure that an appropriate level exists both in terms of capacity and competency.
• Develop a plan to establish a 24/7 web-based video interpretation program alongside recruitment of a manager to oversee this initiative.
• Expand the number of video conferencing terminals with access to healthcare interpretation technology.
• Hire and train certified translation staff to better enable translation of written documents alongside provision of web-based video interpretation services.
• Increase the number of interpreter encounters per month as a measure of improving language access to the patient population.
• Participate in face-to-face learning as a quality improvement process that promotes lessons learned, solutions, and opportunities with other providers in region.

In 2012, University Health System began the process of implementing an integrated interpreter education and competence assessment program. This 40-hour training program is for bilingual University Health System staff to provide healthcare interpretation services within their own clinical or administrative areas. The training includes: modes of interpretation, the role of the interpreter, code of ethics and confidentiality, medical terminology, and practice. Successful completion of the program requires regular class attendance, passing the final written exam, and a final demonstration of competence in an interpreting skills practice situation.

To date, University Health System has trained 108 interpreters through this program. 106 of these individuals serve as English/Spanish language interpreters. The remaining two are English/German interpreters.

Challenges
While this program marks a significant improvement over University Health System’s previous model of depending exclusively on costly contracted vendors to provide telephonic interpreters and onsite interpretation services at our locations, there continues to be challenges. These include:
1) Having a limited menu of language-specific interpretation services that are available through the in-house program. For example, there is significant and often emergency need for interpreters of languages of lesser diffusion, including Farsi, Arabic, Russian, Vietnamese and Karen
2) The limited capacity that exists for trained staff interpreters to support other units within the hospital, or at another University Health System location due to scheduling and primary job responsibilities and requirements.
3) Disparate distribution of interpreters by shift offers limited availability for after hours and weekend interpretation services
4) In situations in which pre-scheduling is not possible, such as emergencies, the time for a staff interpreter or an outside vendor to arrive onsite can often impact timeliness of care (arrival time can be greater than one hour).

5-Year Expected Outcome for Provider and Patient
University Health System expects to strengthen access to culturally competent patient-centered care through a fully established language interpretation program marked by an increase in training staff (150), implementation a 24/7 web-based interpretation technology and an established standard document translation process that promotes timely oral and written interpretation/translation services, improves exchange of health information between patients and
healthcare professionals and increases patient confidence in adherence to clinical care and treatment.

**Starting Point/Baseline:**
Currently, there are 108 certified medical interpreters at University Health System. The most recent available interpreter support services data report that in 2011 there were approximately 82,984 minutes of telephonic interpretation, 1,702 on-site contract interpretation encounters and 205 documents translated in Spanish.

**Rationale:**
In the United States, safety-net hospitals remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. These populations are considered diverse both in terms of ethnicity, language and cultural background. Therefore expanding access to written and oral interpretation services firmly coincides with University Health System strategic imperative and national health care aims of providing high quality care, improving population health and providing that care in a cost-effective manner; University Health System will primarily focus on developing and implementing an, “infrastructure of culturally competent care.” This will include increasing the number of trained staff interpreters to 150 by the end of 2013 to provide greater in-house interpretation coverage. This will be enhanced by utilizing new and emerging web-based video technologies alongside development of a 24-hour Healthcare Interpreter Service within University Health System. The development of the in-house Healthcare Interpreter Service will occur in 2013, with the recruitment of a manager and the development of objectives and metrics for the program. In 2013, University Health System will evaluate available web-based video interpretation programs, with implementation to follow in 2014. By the end of 2014, University Health System’s Healthcare Interpreter Service will be to full capacity (4.5 FTEs) and operational thus providing 24/7 service.

There is also considerable need to improve the clarity and quality of instructions, letters, signs and other important health information and education documents. Assuring they are written at the appropriate grade level and are consistent with University Health System's commitment to patient centered care and cultural sensitivity is a high priority. University Health System will utilize the new Healthcare Interpreter Service team to reduce written translation expense and enhance the document translation process. The persons hired into these positions will be certified healthcare translators so, during those times when they are not interpreting, they can be translating documents from English to Spanish. The process will be standardized to assure all patient information requiring translation is first assessed by a communications professional for clarity, cultural sensitivity and appropriate grade level, and the translated documents are then evaluated by the volunteer bi-lingual University Health System Translation Committee for quality control purposes.

This project uniquely addresses community health need (CN.1) Improve quality of healthcare delivery and patient experience and (CN.2) address the high prevalence of chronic disease and related health disparities in the community through greater prevention efforts that focus on addressing chronic disease.

In terms of system redesign, this project represents an opportunity to develop effective methods
of translation and communication which are considered critical to delivering safe, timely and effective health care, and ensuring open communication between patients, families and healthcare team members. Communication is also directly linked to adherence to medication regimens, provider recommendations, and hospital discharge instructions. Communication that is respectful of a patient’s cultural orientation can result in better health outcomes and reduced readmission rates. Conversely, inadequate interpretation services and/or culturally or linguistically inappropriate health education materials can lead to patient dissatisfaction, poor comprehension and adherence, and uncoordinated low-quality care.

To attain the highest level of communication and cultural competence, healthcare providers must be aware of the impact of cultural factors on their patients’ health beliefs and behaviors, and have the tools and skills needed to communicate effectively and appropriately with a diverse population of patients. At the same time, patients must be empowered to be an active partner in this process.

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
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<tbody>
<tr>
<td><strong>OD- Patient Satisfaction</strong></td>
</tr>
<tr>
<td><strong>IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)</strong></td>
</tr>
<tr>
<td>Percent improvement over baseline of patient satisfaction scores, among non-English speaking patients, for one or more of the patient satisfaction domains that the provider targets for improvement utilizing the HCAHPS survey.</td>
</tr>
<tr>
<td>a Numerator: Percent improvement in targeted patient satisfaction domain</td>
</tr>
<tr>
<td>b Data Source: Patient survey</td>
</tr>
<tr>
<td>c Denominator: Number of patients who were administered the survey</td>
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**Reasons/Rational for Selecting the outcome measures:**
The patient satisfaction outcome measure was selected due to its consideration as a valid self-report rating by the patient in regards to the quality of care received during their most recent appointment. Further, the intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

With a service catchment area of 1.7 million residents, University Health System is the major safety-net hospital for Bexar County, Texas. Ensuring that timely, efficient, equitable, high quality care is delivered to the population will be strengthened by taking into account and measuring the patient perspective thus translating into better health for the community.

Further, effective communication impacts the patient’s perception of every dimension of care included in the CAHPS surveys. How they rate their experience in a hospital or outpatient
facility starts with understanding what their doctor, nurse or other healthcare worker said to them. How these professionals relate to their patients (e.g. demonstrating respect for a different culture) is critical to improving patient satisfaction scores and directly linked to patient adherence to treatment plans and medication regimens. Developing a culture in which competent healthcare interpreters are utilized in all situations in which the patient and provider speak different languages is an important way to reduce patient anxiety, foster understanding between the entire healthcare team (with the patient as its central member), and improve the patient experience. What is best for patients is the most important rationale for selecting this project and for measuring its success through CAHPS scores.

**Relationship to other Projects:**

<table>
<thead>
<tr>
<th>Category 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Project ID: 136141205.1.4) <strong>Introduce, Expand or, Enhance Telemedicine/Telehealth.</strong> Expanding and integrating culturally competent patient-centered care through strategies that promote timely oral and written interpretation/translation services, improve exchange of health information between patients and healthcare professionals and increase patient adherence to provide protocols and better health outcomes.</td>
</tr>
<tr>
<td>(Project ID: 136141205.1.2) <strong>Expand Primary Care Capacity.</strong> Expanding and integrating culturally competent patient-centered care through strategies that promote timely oral and written interpretation/translation services, improve exchange of health information between patients and healthcare professionals and increase patient adherence to clinical care and better health outcomes.</td>
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<tr>
<th>Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Project ID: 92414401.2.2) <strong>Enhance/Expand Medical Homes:</strong> Expansion and integration culturally competent patient-centered care within the medical home allows for the provision of care with the patient at the right time and in the right setting and for managing co-morbid mental health and physical conditions in a coordinated, holistic way.</td>
</tr>
<tr>
<td>(Project ID: 92414401.2.1) <strong>Expand Chronic Care Management Models:</strong> Interventions that are culturally tailored can strengthen adherence to treatment and self-management and thereby lead to improved health outcomes and quality of care, potentially helping to reduce unnecessary hospitalizations and ER visits.</td>
</tr>
<tr>
<td>(Project ID: 136141205.2.2) <strong>Redesign to Improve Patient Experience:</strong> Providing increased access to language and interpretation services within the medical home in a coordinated and patient-centered manner can strengthen and enhance the patient care experience.</td>
</tr>
<tr>
<td>(Project ID: 136141205.2.3) <strong>Apply Process Improvement Methodology to Improve Quality/Efficiency.</strong> Tailoring language and interpretation services through assessment alongside patient and staff feedback can improve process leading to delivery of high quality efficient care.</td>
</tr>
</tbody>
</table>
(Project ID: 136141205.2.4) **Establish/Expand a Patient Care Navigation Program:** Expanding delivery of culturally competent care in the medical home will enhance the opportunity for care navigation staff to provide appropriate care in the right setting to patients vulnerable to admission and readmission in inpatient settings.

**RD-4. Patient-centered Healthcare**  
1. **Patient Satisfaction**  
The reporting of the measures must be limited to the inpatient setting only. All of the HCAHPS’ questions included for the themes listed below are required to be included in RHP plans for PPs required to report for DY 2-5, or if HCAHPS not in place in DY 2, starting DY 3.  
a. Each HCAHPS theme includes a standard set of questions. The following HCAHPS’ themes will be reported on:  
   • Your care from doctors;  
   • Your care from nurses  
   • The hospital environment;  
   • When you left the hospital.  
b. Data Source: HCAHPS296

**Relationship to Other Performing Providers’ Projects in the RHP:**

**Plan for Learning Collaborative:**  
University Health System is already actively engaged with peer organizations in an interpretation services learning collaborative through the Teaching Hospitals of Texas. This demonstration project will further the work of this learning community and expand its ability to share ideas and challenges with providers across the state. University Health System looks forward to developing a plan to communicate lessons learned from this project across RHP 6 and organize learning events within the region to bring interpretation/translation communications experts in from outside the region to share knowledge and best practices around this important issue.

**Project Valuation:**  
This project, to improve communication and foster understanding between healthcare providers, patients and families, is directly tied to the Waiver’s Triple aim to assure patients receive high quality and patient-centered care, in the most cost effective ways.

Project valuation for strengthening access to culturally competent patient-centered care through strategies that promote timely oral interpretation/translation services, improve exchange of health information between patients and healthcare professionals and increase patient confidence in adherence to clinical care directly responds to waiver goals including the triple aim and improving the health delivery infrastructure to better serve the uninsured residents of the community and region. This includes providing care in the right setting at the right time and in a manner that enhancing the provider’s ability to address patient adherence to treatment, clinical preventive care and discharge instructions, both of which may contribute to avoidance of unnecessary admissions and ER visits that might be due to untreated mental illness.
The project also addresses community need by responding to efforts that improve quality of healthcare delivery and patient experience as well as reducing the high prevalence of chronic disease and related health disparities in the community.

This project is considered is appropriate in scope (Scale Rating: 4) with the potential to make a large impact as it looks to enhance an infrastructure that is coordinated and improves patient outcomes, as these objectives cannot be attained without effective interpersonal communication.

Relative to other projects, the proposed efforts is in scale and will require investment in human resources, technology and organizational priorities that strengthen the quality and value of care delivered to the target population.
<table>
<thead>
<tr>
<th>136141205.1.7 PASS 2</th>
<th>1.4.1</th>
<th>A-D</th>
<th>1.4.1 Expand Access to Written and Oral Interpretation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital</td>
<td>TPI - 136141205</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.19</td>
<td>3.1T-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td><strong>Year 2</strong> <em>(10/1/2012 – 9/30/2013)</em></td>
<td><strong>Year 3</strong> <em>(10/1/2013 – 9/30/2014)</em></td>
<td><strong>Year 4</strong> <em>(10/1/2014 – 9/30/2015)</em></td>
<td><strong>Year 5</strong> <em>(10/1/2015 – 9/30/2016)</em></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Conduct an analysis to determine gaps in language access and culturally competent care. <strong>Metric 1</strong> [P-1.1] Submit gap analysis report. Baseline: 0 Data Source: Gap analysis</td>
<td><strong>Milestone 3</strong> [P-X]: Develop plan to establish a 24/7 web-based video interpretation program to include recruiting a program manager. <strong>Metric 1</strong> [P-X.1]: Submit plan Baseline: 0 Data Source: 24/7 Interpreter Service Plan</td>
<td><strong>Milestone 7</strong> [P-5]: Hire and train certified Spanish translation staff to translate written documents and provide web-based video interpretation services 24/7. <strong>Metric 1</strong> [P-5.1]: Expand capacity of qualified staff to be immediately available to interpret and translate documents in-house. Baseline: 0 Goal: 24-hour coverage Data Source: automated report from vendor &amp; encounter data</td>
<td><strong>Milestone 10</strong> [P-12] Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 1</strong>: P-14.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 0 Goal: To conduct two seminars</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-5]: Train additional volunteer health care interpreters and assess their competency. <strong>Metric 1</strong> [P-5.1] Expand qualified health care interpretation workforce. Baseline: 108 interpreters Goal: 30 additional certified interpreters. Data Source: Interpreter</td>
<td></td>
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<tr>
<td><strong>Milestone 4</strong> [P-4]: Expand qualified health care interpretation technology <strong>Metric 1</strong> [P-4.1]: Video conferencing interpreter terminals with access to health care interpretation technology. Numerator: Number of terminals</td>
<td><strong>Milestone 8</strong> [P-5]: Train additional volunteer health care interpreters and assess their</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $1,679,940</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $ 917,766.50</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $1,231,600.67</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong></td>
</tr>
</tbody>
</table>

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293  ★  RHP 6 Plan  ★  March 8, 2013  University Hospital
Milestone 2
Estimated Incentive Payment: $1,679,940
Available within University Health System facilities. Denominator: Total number of video conferencing terminals in the health system.
Baseline: 0
Goal: TBD
Data Source: Automated report from selected vendor and encounter data report

Milestone 4
Estimated Incentive Payment: $917,766.5

Milestone 5
[P-5]: Train additional volunteer health care interpreters and assess their competency.
Metric 1 [P-5.1] Expand qualified health care interpretation workforce.
Baseline: 138 interpreters
Goal: 40 additional certified interpreters.
Data Source: Interpreter training data

Milestone 5 Estimated Incentive Payment: $917,766.5

Milestone 8
Estimated Incentive Payment: $1,231,600.67

Milestone 9
[I-13]: Improve language access
Metric 1 [I-3.1]: The number of qualified health care interpreter encounters per month based on one of the reporting months within the prior year.
Numerator: Total number of remote video/voice and/or in-person interpreter encounters recorded per month.
Denominator: Total number of encounters recorded per month from previous year.
Baseline: 1,000
Goal: 1,250 interpretation encounters by the end of DY4.
Data Source: Automated report or meetings to promote collaborative learning in a year.
a. Data Source:
Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
b. Rationale/Evidence:
Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

Milestone 10
Estimated Incentive Payment: $1,016,173

Milestone 11
[P-5]: Train additional volunteer health care interpreters and assess their competency.
Metric 1 [P-5.1] Expand qualified health care interpretation workforce.
Baseline: 218 interpreters
Goal: 40 additional certified interpreters.
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
<th>Estimated Incentive Payment</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 [I-13]</td>
<td><strong>Improve language access</strong>&lt;br&gt;Metric 1 [I-3.1]: The number of qualified health care interpreter encounters per month based on one of the reporting months within the prior year. Numerator: Total number of remote video/voice and/or in-person interpreter encounters recorded per month. Denominator: Total number of encounters recorded per month from previous year. Baseline: 0 Goal: 1,000 interpretation encounters by the end of DY3. Data Source: Automated report &amp; encounter data.</td>
<td>$1,231,600.67</td>
<td>Interpreter training data</td>
</tr>
<tr>
<td></td>
<td>Milestone 9 Estimated Incentive Payment: $1,231,600.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 10 Estimated Incentive Payment: $1,016,173</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Improve language access</strong>&lt;br&gt;Metric 1 [I-3.1]: The number of qualified health care interpreter encounters per month based on one of the reporting months within the prior year. Numerator: Total number of remote video/voice and/or in-person interpreter encounters recorded per month. Denominator: Total number of encounters recorded per month from previous year. Baseline: 1,500 Goal: TBD Data Source: Automated report &amp; encounter data.</td>
<td>$1,231,600.67</td>
<td>Interpreter training data</td>
</tr>
<tr>
<td></td>
<td>Milestone 11 Estimated Incentive Payment: $1,016,173</td>
<td></td>
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</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $3,359,880 | Year 3 Estimated Milestone Bundle Amount: $3,671,066 | Year 4 Estimated Milestone Bundle Amount: $3,694,802 | Year 5 Estimated Milestone Bundle Amount: $3,048,519 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,774,267**
### Project Summary:

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty, and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** Increase pediatric primary care (including pediatric urgent care) clinic visit volume and provide evidence of improved access for patients seeking services. Accomplish this intervention through hiring more pediatricians and mid-level providers to enhance access for pediatric patients.

**Need for the project:** Our goal is to increase access to quality pediatric care in Bexar County, Texas. This will be accomplished by expanding the existing health service model of care to more fully support delivery of pediatric health services including expanding hours of operations at primary care clinic sites and increasing number of pediatric clinicians to more fully support segments of the pediatric population in need of preventive care and treatment. Studies find that economically vulnerable populations including minority children are much less likely to have access to timely and appropriate health care.

**Target population:** The target population will include pediatric patients in either an indigent or Medicaid-qualifying status in Bexar County who are in need of accessible primary care in areas of the city convenient to where they live.

**Category 1 or 2 expected patient benefits:** We anticipate that this project will produce the following benefits for the targeted population:

- Provide more timely access to clinical preventive services and screening in order to prevent and detect disease
- Addresses community need three (CN.3), lack of medical and dental health services in the community due high rates of uninsurance and provider shortages
- Serve to reduce health inequities and address the triple aim of providing high quality care, improving population health and reducing the per capita cost of health care.

The University Health System will improve access for pediatric primary care and pediatric urgency care services by demonstrating an increase in volume of services provided in DY2 through DY5. For the baseline year beginning October 1st, 2011 and ending September 30th,
In 2012, there were 66,435 CMA pediatric primary care and pediatric acute care encounters.

- **DY3** – Increase CMA pediatric primary and acute care encounters by 2% over baseline; 67,764 expected encounters.
- **DY4** – Increase CMA pediatric primary and acute care encounters by 4% over baseline; 69,092 expected encounters.
- **DY5** – Increase CMA pediatric primary and acute care encounters by 6% over baseline; 70,421 expected encounters.

**Category 3 outcomes:** IT-9.3- Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381 (Standalone measure). Reduction of pediatric and young adult asthma emergency department visits by TBD% by the ends of both DY4 and DY5 for the target population.

**Project Description:**

Our goal is to increase access to quality pediatric care in Bexar County, Texas. This will be accomplished by expanding the existing health service model of care to more fully support delivery of pediatric health services including, expanding hours of operations at primary care clinic sites and increasing number of pediatric clinicians to more fully support segments of the pediatric population in need of preventive care and treatment. These goals aim to improve delivery of high quality evidence-based clinical preventive services to special populations that consist of screening and immunizations that can prevent disease and encourage healthy behavior and adherence to preventive care from a very young age. It is estimated that 22 million children lack access to medical care due to provider shortages (Patient Protection and Affordable Act, 2012). Disparities in access to health care services are also due to the high cost of care as well as the result of being uninsured. These factors can have a deleterious effect on the health status of individuals such as delays in seeking care or treatment, the inability to receive timely clinical preventive care (immunizations) and screening (obesity, asthma) for conditions that untreated can consequently result in admissions to the emergency room (Healthy People 2020). Studies find that economically vulnerable populations including minority children are much less likely to have access to timely and appropriate health care. This occurs at a time when minorities are contributing to a major demographic shift in this nation. For example, minority children account for almost half (46%) of the population under 18 (Annie E. Casey Foundation, 2011). Within the past decade, Hispanic children grew by 4.8 million (or 39 percent). Local data for Bexar County, illustrate similar trajectories in racial/ethnic minority growth. For example, a recent demographic assessment estimates that almost one third of the population will be 18 years of age or younger, with 9 out 10 being of Hispanic origin.

Delivery of evidence-based clinical preventive services (i.e., immunizations, screenings), and the integration of these activities within a primary care setting are central to improving and enhancing the health status of children in Bexar County, Texas. Enhancing access to pediatric health services support implementation of community-based preventive services and enhance linkages with clinical care, especially among populations at greatest risk for disease and injury.
Specific Project Goals

This project will increase and expand access to pediatric health care within the University Health System medical home model of care by collaborating with both current and planned community health service interventions that will take place within the geographic service catchment area of University Health System, resulting in expansion of services. Specifically this project will:

- Reduce disparities in access to preventive pediatric health services in underserved populations
- Increase pediatric care provider capacity to ensure timely, accessible and integrated care to underserved pediatric populations in Bexar County, Texas
- Increase awareness among target population on the importance of adherence to clinical preventive care in reducing risk for disease and injury.

This undertaking will be made possible by leveraging the University Health System ambulatory network of clinical and preventive health clinics that are located in both high-growth and high-need areas delineated primarily by economically vulnerable populations that include minority individuals with multiple chronic conditions with limited and non-existent health insurance coverage. For example project efforts will coincide with University Health System initiatives to partner with FQHCs to expand primary care capacity and access, oral health services, establish school-based clinics in major urban sectors of the city and health promotion efforts that enhance awareness of preventive care at all life stages to further help establish linkages between communities and preventive care.

The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaborative to be established.

Relationship to Regional Goals

This project will further achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth.

Challenges

Challenges to this project will be the timely expansion and care coordination of pediatric health services to (1) ensure timely receipt of care by patients, (2) ensure appropriate infrastructure (electronic medical record systems), (3) the coordination and capacity (providers, hours of operation and clinical space) to appropriately accommodate increased volume from newly established referral pathways. In an effort to proactively address these challenges strategic planning and assessment efforts will be undertaken that includes meeting with key stakeholders to ensure that a balance is maintained between resources, capacity and projected demand. This is considered essential to providing care at the right time and in the
right setting.

**5 Year Expected Outcome for Provider and Patients:**
University Health System expects to see improvements in clinical linkages (integration and coordination of health services), as well as a fully expanded pediatric health service model of care between University Health System and target population. The anticipated 5 year goal is to reduce the proportion of Pediatric/Young Adult Asthma Emergency Department Visits.

**Starting Point/Baseline:**
Baseline will include 2011 annual number of pediatric primary care and urgency primary care encounters seen at Community Medical Associates Primary Care and Urgent Care sites (encounters include CMA primary care network (Main clinical home, PHC, all locations that provide primary and preventive services).

During the baseline year ending September 30th, 2012, there were 66,435 CMA pediatric primary care and pediatric acute care encounters.

**Rationale:**
Studies find disparities in health and well-being often begin in early in life. The etiology of adverse health events are often a reflection of gaps in access to services that lead unequal treatment, adverse congenital health conditions, as well as early exposure to distressed social and economic conditions (i.e., poverty). Expanding access to pediatric services especially among economically underserved population is central to increasing adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, which is key to reducing death and disability. These strategies are important and strongly coincide with interventions that see to improve the nation’s health (Healthy People 2020, National Prevention Strategy, 2011).

There is clear evidence that timely access to clinical preventive services and screening can both prevent and detect illnesses and disease that range from the flu to cancer that if caught in their earlier, more treatable stages, can significantly reducing the risk of illness, disability, early death, and health care costs. For example, on average, 42,000 deaths per year are prevented among children who receive recommended childhood vaccines. Yet, despite this evidence and such services are now covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act (ACA), large segments of the U.S. population which translate into millions of children, adolescents, and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.

This project addresses the following Core Components:

a) Expand primary care clinic space: University Health System anticipates obtaining new space in a location to be selected in the baseline assessment phase. Milestone 2 was chosen to address this component.

b) Expand primary care clinic areas: We also anticipate adding hours of service in at least one clinic site, potentially more, based on a demand study conducted during the baseline assessment phase, which is reflected in milestone 3.
c) Expand primary care clinic staffing to two or more clinic locations and will determine in the baseline assessment phase where the greatest impact will be for the growing patient population. This component is initially addressed with milestone 1.

This project specifically addresses community need three (CN.3): Address the lack of medical and dental health services in the community due high rates of uninsurance and provider shortages

The current project is a system redesign that enhances the current delivery of care model by leveraging the network of University Health System Preventive Health Clinics in the community. Specifically, these preventive health clinics will help to establish a usual source of care in the population through integration and maintenance that is accessible, coordinated, comprehensive and patient-centered for children and adolescents.

These efforts will therefore serve to reduce health inequities and address the triple aim of providing high quality care, improving population health and reducing the per capita cost of health care; University Health System will engage in population-based interventions that are coordinated, comprehensive and multi-component to more effectively address the health needs of the 1.7 million residents of this major urban Texas region.

With particular emphasis placed on children with health service needs residing in economically underserved areas of Bexar County, this will occur by implementing evidence-based strategies that encourage healthy lifestyles through delivery of clinical preventive services. Such efforts coincide with Healthy People 2020, The National Prevention Council’s National Prevention Strategy to engage and empower individuals, promote healthy and safe communities and align with clinical and community preventive services to reduce disparities in health.

### Related Category 3 Outcome Measure(s):

**Outcome Measure Description:**

**IT-9.3 – Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381**

a. Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.

b. Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary and secondary diagnoses with the dates of service “Begin Date through End Date” equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail"

c. Data Source: EHR, Claims

### Relationship to other Projects:

**This Project is related to:**

136141205.2.1 - Enhance/Expand Medical Homes

Increasing access to primary care will give patients access to other preventive services
offered in the medical homes

136141205.2.3 - Redesign to Improve Patient Experience
Providing the ability to access healthcare in a timely manner and in locations where services are needed will to a better patient experience.

136141205.1.1.3 - Expand Mobile Clinics: University Health System’s Healthy U
Delivery of evidence-based clinical, community preventive services (i.e., immunizations, screening), and the integration of these activities within a school-based setting are central to enhancing the health status of children and adolescents.

Related Category 4 measures include potentially preventable admissions measures in RD-1, 30 day readmissions in RD-2, Patient Satisfaction in RD-4.1 and RD-4.2.

<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI Pending 1.1.1 – Establish more primary care clinics: Primary Care Expansion Program (Children’s Hospital of San Antonio)</td>
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<table>
<thead>
<tr>
<th>Plan for Learning Collaborative:</th>
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<tbody>
<tr>
<td>This project lends itself to participation in a learning collaborative as other Performing Providers in RHP6 seek to develop and expand pediatric care services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve access to pediatric health services.</td>
</tr>
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<table>
<thead>
<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>The project achieves the waiver goal and meets community needs by expanding pediatric care capacity in a predominantly Hispanic, underserved area of Bexar County. This program strengthens healthcare linkages with local community partners and enhances access to health care services to a target population who struggle with poverty, receive acute or emergency healthcare services, and do not have usual providers. In addition, many in the target population often with no or limited access to quality pediatric care are unaware of being at risk or are not diagnosed with conditions which can become far more complicated and costly to treat. Access to coordinated and timely pediatric health services has shown to improve health, improve health care, and lower care costs.</td>
</tr>
</tbody>
</table>
## Related Category 3

**Outcome Measure(s):**
- 136141205.3.25
- IT-9.3
- Pediatric/Young Adult Asthma Emergency Department Visits (Standalone measure)

## Year 2 (10/1/2012 – 9/30/2013)

<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 3</th>
<th>Milestone 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-5]: Train/Hire additional pediatric care providers and staff and/or increase the number of pediatric care clinics for existing providers</td>
<td>[P-1]: Establish additional/expand existing/relocate primary care clinics</td>
<td>[I-12]: Increase pediatric primary care (including pediatric urgent care) clinic volume of visits and provide evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 1 [P5.1]: Documentation of increased number of pediatric providers</td>
<td>Metric 1 [P-1.1]: Number of expanded hours</td>
<td>Metric 1: [I-12.1]: Documentation of increased number of visits</td>
</tr>
<tr>
<td>Baseline: Number of providers in CMA at September 30, 2012</td>
<td>Baseline: baseline year of December 31, 2011 primary care hours</td>
<td>Baseline: During the baseline year ending September 30th, 2012 there were 66,435 pediatric primary care and acute care encounters. Goal: Increase primary pediatric care (including pediatric urgent care) encounters by 6% over baseline (70,421 encounters)</td>
</tr>
<tr>
<td>Data Source: provider templates, HR new hire documentation</td>
<td>Goal: add 1 additional 4 hour session at one clinical site</td>
<td>Data Source:IDX, sunrise and OP activity report</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,762,829.50</td>
<td>Milestone 3 Estimated Incentive Payment: $2,121,032.5</td>
<td>Milestone 6 Estimated Incentive</td>
</tr>
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</table>

## Year 3 (10/1/2013 – 9/30/2014)

<table>
<thead>
<tr>
<th>Milestone 2</th>
<th>Milestone 4</th>
<th>Milestone 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1: Expand Existing pediatric primary care clinics</td>
<td>I-12 Increase pediatric primary care (including pediatric urgent care) clinic volume of visits and provide evidence of improved access for patients seeking services</td>
<td>I-12: Increase pediatric primary care (including pediatric urgent care) clinic volume of visits and provide evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 1: [I-12.1]: Documentation of increased number of visits</td>
<td>Metric 1: [I-12.1]: Documentation of increased number of visits</td>
<td>Metric 1: [I-12.1]: Documentation of increased number of visits</td>
</tr>
<tr>
<td></td>
<td>Baseline: During the baseline year ending September 30th, 2012 there were 66,435 pediatric primary care and acute care encounters. Goal: Increase primary pediatric care (including pediatric urgent care) encounters by 4% over baseline (69,092 encounters)</td>
<td>Baseline: During the baseline year ending September 30th, 2012 there were 66,435 pediatric primary care and acute care encounters. Goal: Increase primary pediatric care (including pediatric urgent care) encounters by 6% over baseline (70,421 encounters)</td>
</tr>
<tr>
<td></td>
<td>Data Source:IDX, sunrise and OP activity report</td>
<td>Data Source:IDX, sunrise and OP activity report</td>
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## Year 4 (10/1/2014 – 9/30/2015)

<table>
<thead>
<tr>
<th>Milestone 5</th>
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<tbody>
<tr>
<td>I-12: Increase pediatric primary care (including pediatric urgent care) clinic volume of visits and provide evidence of improved access for patients seeking services</td>
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</tbody>
</table>

## Year 5 (10/1/2015 – 9/30/2016)

<table>
<thead>
<tr>
<th>Milestone 6</th>
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</thead>
<tbody>
<tr>
<td>I-12: Increase pediatric primary care (including pediatric urgent care) clinic volume of visits and provide evidence of improved access for patients seeking services</td>
</tr>
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University Hospital
<table>
<thead>
<tr>
<th>Metric 1 P-1.1: Number of additional square footage for exam rooms at existing clinics designated for delivery of pediatric primary and urgent pediatric care.</th>
<th>Baseline: During the baseline year ending September 30th, 2012 there were 66,435 pediatric primary care and acute care encounters. Goal: Increase primary pediatric care (including pediatric acute care) encounters by 2% over baseline (67,764 encounters) Data Source: IDX, sunrise and OP activity report</th>
<th>Milestone 5 Estimated Incentive Payment: $4,420,095</th>
<th>Payment: $3,730,722</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: Square footage designated for pediatric primary and urgency care at year end December 31, 2011. Goal: Increase square footage designated for delivery of pediatric primary and urgency care by 250 sq. ft. Data Source: documentation of detail expansion plans/drawings</td>
<td>Milestone 4 Estimated Incentive Payment: $2,121,032.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $1,762,829.50</td>
<td>Milestone 6 Estimated Incentive Payment: $3,730,722</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,525,659</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,242,065</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,420,095</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 15,918,541</td>
</tr>
</tbody>
</table>
**Identifying Project and Provider Information:**

| Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system Psychiatric Emergency Services (PES) |
| Unique RHP ID#: 136141205.1.9 - PASS 3 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

**Project Summary:**

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** This project proposes development and expansion of a psychiatric emergency service with capacity to accommodate voluntary and involuntary patients with mental illness and in acute crisis. It offers an alternative to medical emergency rooms for those patients not requiring emergent/urgent evaluation and stabilization of physical medical conditions. Partnering this effort with other inventions, like a crisis intervention unit, is critical in order to prevent psychiatric crises and to intervene effectively when they do arise.

**Need for the project:** A study of the Bexar County Mental Health System identified the following problems: stacking in the ER, increase in emergency detention patients (brought in by law enforcement), lack of psychiatrists, and increase use of the criminal justice system by these patients. During a six-month period (July 1 – December 31, 2009), 2,580 indigent patients with mental health diagnoses were evaluated in emergency rooms across San Antonio (accounted for 37.5% of total emergency room patients with mental illness diagnoses) at a total cost of $2.1M. Of those evaluated, 7% were return visits during the same period. As indicated in the RHP 6 Community Needs Assessment this project meets the regional goal to increase access to outpatient care for adults with moderate acuity behavioral health needs in order to mitigate readmissions for acute care services and the inappropriate use of emergency departments.

**Target population:** Patients in Bexar County who traditionally access the emergency department for behavioral health care interventions. Bexar County has a significant number of low income, uninsured and minority residents who suffer from multiple chronic conditions. The majority of our patients are either Medicaid eligible, underinsured, or indigent. Patients will benefit from this project by receiving quality care in the most appropriate setting.

**Category 1 or 2 expected patient benefits:** This project will assure that the right care is being provided in the right setting (OD-9.3.1) and includes the following components:

- Expand the system of care by creating a psychiatric emergency service (PES)
- Increase access to an underserved patient population by hiring additional psychiatrists and psychiatric nurse practitioners to provide evaluations urgently and emergently
• Treating patients in the safest and most appropriate setting with access to psychiatric expertise

We anticipate a patient benefit through provision of an estimated number of PES visits of 1,200 during DY4 and 2,400 in DY5.

Category 3 outcomes: IT 3.8 The goal is to reduce Behavioral Health/Substance Abuse ED visits in the medical ED

• DY4 – Reduce readmission rates by TBD%
• DY5 – Reduce readmission rates by TBD%

Project Description:
In March, 2011, a study of the Bexar County Mental Health system was conducted by U.S. Army Department Army-Baylor Program Intern, Major Samantha S. Hinchman, often referred to in the community as the “Hinchman Study” and focused on indigent care for behavioral health patients presenting to local hospital emergency rooms. The study identified the following problems: stacking in the ER, increase in emergency detention patients (brought in by law enforcement), lack of psychiatrists, and increase use of the criminal justice system by these patients. During a six-month period (July 1 – December 31, 2009), 2,580 indigent patients with mental health diagnoses were evaluated in emergency rooms across San Antonio (accounted for 37.5% of total emergency room patients with mental illness diagnoses) at a total cost of $2.1M. Of those evaluated 7% were return visits during the same period. During 2011, University Hospital provided emergent psychiatric evaluations for 3,127 patients, 50% of whom were brought in by law enforcement. The length of stay for those patients deemed voluntary was 16 hours, and for those needing involuntary admission was 37 hours (average 18 hour LOS). Because of the volume of patients and length of stay, a back log in the medical emergency room is experienced by patients with and without psychiatric conditions. In addition, stabilization of crises occurs more readily in a site where psychiatric providers are readily available, thus potentially avoiding unnecessary inpatient admissions.

This project proposes to expand on that assessment of community need and develop and expand a psychiatric emergency service with capacity to accommodate voluntary and involuntary patients with mental illness and in acute crisis. This solution would offer an alternative to medical emergency rooms for those patients not requiring emergent/urgent evaluation and stabilization of physical medical conditions. The capacity would be 16 beds.

This project will assure that the right care is being provided in the right setting (OD-9.3.1) and includes the following components:

• Expand the existing system of care by creating a psychiatric emergency service (PES)
• Increase access to an underserved patient population by hiring additional psychiatrists and psychiatric nurse practitioners to provide evaluations urgently and emergently
• Treat patients in the safest and most appropriate setting with access to psychiatric expertise

Anticipated challenges include financial sustainability and recruitment of psychiatrists and
mid-level behavioral health providers. From a financial perspective this project addresses the underserved needs of indigent behavioral health patients in the San Antonio community. The lack of treatment resources for the indigent mental health patient is a community problem which we hope to significantly address through this project. Multi-year expected outcomes include the PES (and its sister project the Crisis Intervention Unit, CIU) becoming integrated within a community-wide behavioral health system of care with seamless transitions between hospital-based services (ER’s and inpatient units) to community outpatient settings. The project goal is to enable immediate access for patients to urgent/emergent care with interdisciplinary expertise, and stabilization of crises in a more appropriate setting than a hospital inpatient unit.

Another challenge is the ability to recruit psychiatrists to our community since that specialty is under-represented already. Thus we anticipate using a staff model of some employed psychiatrists and mid-level providers, supplemented by providers contracted hourly, and those made available through telemedicine.

As indicated in the RHP 6 Community Needs Assessment this project meets the regional goal to increase access to outpatient care for adults with moderate acuity behavioral health needs in order to mitigate readmissions for acute care services and the inappropriate use of emergency departments.

**Starting Point/Baseline:**

The annual number of admits to the Hospital’s psychiatric emergency service is 3,127 (2011). We hope to increase this number to include those patients who now would present to an emergency room not having psychiatric evaluation capability.

We anticipate that once the psychiatric emergency service is opened and community education to EMS, health care systems, and law enforcement, is completed, that volume of services will increase fairly quickly. Ongoing data collection should include:

- Number of patient visits
- Number of unduplicated patients evaluated
- Number of patients brought in by law enforcement (emergency detention or otherwise), EMS, walk-in, or transferred
- Identification of frequent utilizers of these services
- Payer mix
- Length of stay
- Final disposition: including # admitted to University Hospital psychiatry inpatient unit or other unit, # referred to other crisis stabilization services, # referred to outpatient treatment
- Quality indicators
**Rationale:**

This project was selected due to the critical need for emergency psychiatric care for patients that do not otherwise need medical treatment for a physical condition. Providing psychiatric emergency services will facilitate care for psychiatric patients in the most appropriate treatment setting. In addition it will decrease emergency room traffic in medical care settings for those with primary psychiatric diagnoses who can be appropriately served in other settings thereby enhancing throughput in that setting for medical patients. Finally, with availability of psychiatric staff and other support staff, unnecessary admissions can be avoided by providing crisis intervention in a setting more appropriate than a medical emergency room without such support and facility structure conducive to stabilizing psychiatric crises.

It is responsive to Community Need #4 (CN4): Address the shortage of high quality integrated mental and behavioral health services in the community.

This project significantly enhances the way we will provide care to patients seeking emergent or urgent psychiatric services. It allows patients to be seen in the most appropriate setting by the most appropriate health professional. It offers an alternative to medical emergency rooms for those patients not requiring emergent/urgent evaluation and stabilization of physical medical conditions.

The following core components will be addressed:

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

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

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

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

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

**Related Category 3 Outcome Measure(s):**

**IT-9.2 ED appropriate utilization (Standalone measure)**
- Reduce Emergency Department visits for target conditions
  - Behavioral Health/Substance Abuse

A literature review of high utilizers of emergency room services for psychiatric services indicates that frequent users typically have clinical conditions such as alcohol or drug use. In addition, significant social barriers such as housing, lack of health insurance, poor social support and lack of transportation were identified. This project serves to evaluate patients in psychiatric crisis and to stabilize the crisis within a psychiatric emergency service in order to avoid clogging hospital medical emergency departments, to divert to crisis stabilization services outside of a hospital decreasing the length of stay in University Hospital’s ER.


This evidence provides support for why we feel that that project proposed will produce the outcomes targeted through the project.

The outcomes targeted in this project are a priority for the regional health partnership due to the potential impact on effective operations of emergency departments in the community for the benefit of all populations served there, including low-income populations. These outcomes also improve health delivery both for those patients with medical, non-behavioral health diagnoses and those patients with behavioral health diagnoses as both patient populations are treated in a setting appropriate to their condition.

**Relationship to other Projects:**

The two projects for RHP 6 that relate to this project applying to the same population and geography are:
- 136141205.2.1 2.12.1 Develop, implement, and evaluate standardized clinical
protocols and evidence-based care delivery model to improve care transitions. (University Health System)

- 136141205.1.5 1.9.2 Expand access to specialty care (outpatient psychiatry) to provide follow-up after hospitalization. With increased timely access to outpatient services, particularly post hospital discharge, use of hospital-based emergency and inpatient services is reduced. (University Health System)

- 1.13.2 Crisis Intervention Unit and Intensive Outpatient Program Development (Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization). Access to these services may also mitigate unnecessary emergency room evaluations. (University Health System)

<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
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<tbody>
<tr>
<td>Camino Real Community Services proposes the development of a behavioral health crisis stabilization service with a target population outside of Bexar County; however, sharing of experiences could serve to support a learning collaborative focused on this type of intervention to share ideas, lessons learned, and implementation strategies, successes and barriers.</td>
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<tr>
<th>Plan for Learning Collaborative:</th>
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<tr>
<td>This project is proposed through the same performing provider that serves as the anchor of the RHP6. Thus we are very invested in developing and supporting learning collaboratives. Camino Real Community Services is proposing a similar project, thus creating a natural learning collaborative opportunity between our two organizations. In addition, the Bexar County Commissioners Court Mental Health Consortium identified that the unavailability of crisis services is a gap in Bexar County. Therefore, the Consortium offers an already identified group of stakeholders who would be willing to participate in the sharing and testing of new ideas and solutions with regard to implementation and sustainability.</td>
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<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth). This project addresses community needs by improving access to care for persons with mental illness in crisis and who need immediate access to medical and psychiatric evaluation and subsequent stabilization in a setting outside of inpatient hospital setting when appropriate.</td>
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</table>

This project is based on a 16 bed psychiatric emergency service (PES). The project is designed to provide services to individual’s age 18 years and above with <24 hour LOS. Populations served will include individuals with mental health and/or substance abuse diagnosis. The model is based on expanding mental health resources in our community.

Operating assumptions include a staffing model similar to the following:
**PES (for 16 bed capacity):**

- RN 2 per shift 24/7 = 9 FTE
- MHT 2 per shift 24/7 = 9 FTE
- Social Worker = 1.5 FTE
- MD (psychiatrist): Monday – Sunday 16 hours per day = 2.8 FTE
- MD Psychiatric Medical Director Admin Time = 0.2 FTE
  
  **(NOTE: If PES is not co-located with CIU, and is free-standing, then 24/7 MD coverage is needed for restraint orders = 4.7 FTE)**
- NP: 1 FTE 24/7 + 1 additional NP during hours MN-8am Monday – Sunday = 6 FTE’s
  
  **NOTE: NP + MD coverage provides for 2 providers 24/7**
- Unit Secretary 1 per shift 24/7 = 4.5 FTE
- Nurse Manager = 1 FTE
- Volume assumptions were projected based on historical data for peak hours between 10 am-11 pm which captures 75% of the patients evaluated in UHS emergency department annually.
- Supplies (pharmaceuticals, meals, linens, etc) estimated to be $36-$46 per patient day
- Leased space estimated at between $1,000,000 and $1,600,000 per year
- Insurance estimated to be $5,000 to $15,000 per year

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**PES Volume Calculation**

- 6,886 cases in the community/6 months (Hinchman Study) of which 50% are discharged without admission
- 6,886 cases X 18 hours (average LOS in PES 2011) =123,948 total hours for 6 months or 247,896 hours annualized
- Estimate that we would attract half of the cases in the city, thus 123,948 hours annualized for patients that would arrive at this unit.
- Based on a 24 hour service in the unit and an 18 hour average length of stay our estimated average daily census is 14 patients (assuming efficient turn-over of beds)
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>136141205.3.26</th>
<th>IT-9.2</th>
<th>ED appropriate utilization (Standalone measure)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Milestone 3</th>
<th>Milestone 4</th>
<th>Milestone 5</th>
<th>Milestone 6</th>
</tr>
</thead>
</table>

**Milestone 1**

P-1. Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers.

P-1.1. Metric: Number of meetings and participants. Goal: 2 planning meetings will be held.

Data Source: Attendance lists

Milestone 1 Estimated Incentive Payment: $1,762,829.50

**Milestone 2**

P-2. Conduct mapping and gap analysis of current crisis

**Milestone 3**

P-3: Develop implementation plans for psychiatric emergency services

Metric 1 [P-3.1]: Baseline/Goal: Produce data-driven written action plan for development of specific psychiatric emergency services that are needed based on gap analysis and assessment of needs

Data Source: Written plan

Milestone 3 Estimated Incentive Payment: $1,414,021.67

**Milestone 4**

P-4. Hire and train staff to implement identified crisis stabilization services.

P-4.1. Metric: Number of staff hired and trained.

**Milestone 5**

P-5. Implement identified crisis stabilization services.

Milestone 5 Estimated Incentive Payment: $1,762,829.50

**Milestone 6**

P-6. Evaluate and continuously improve crisis services

P-6.1. Project planning and implementation documentation demonstrates either plan, do, study, act or Lean quality improvement cycles

Goal: conduct 2 quality improvement cycles

a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 6 Estimated Incentive Payment: $1,414,021.67

**Milestone 7**

P-7. Evaluate and continuously improve crisis services

P-7.1. Project planning and implementation documentation demonstrates either plan, do, study, act or Lean quality improvement cycles

Goal: conduct 2 quality improvement cycles

a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 7 Estimated Incentive Payment: $1,762,829.50

**Milestone 8**

P-8. Evaluate and continuously improve crisis services

P-8.1. Project planning and implementation documentation demonstrates either plan, do, study, act or Lean quality improvement cycles

Goal: conduct 2 quality improvement cycles

a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 8 Estimated Incentive Payment: $1,414,021.67
### Goal: Hire and train the appropriate number of staff consistent with a staffing plan like that listed above.
- **a. Staff rosters and training records**
- **b. Data Source: Training curricula**

**Milestone 4**
Estimated Incentive Payment: $1,414,021.67

### Milestone 5
**P-5.** Milestone: Develop administration of operational protocols and clinical guidelines for crisis services.
- **P-5.1. Metric: Completion of policies and procedures.**
  - Goal: Complete policies and procedures for crisis services.
  - **a. Data Source: Internal policy and procedures documents and operations manual.**

**Milestone 5 Estimated Incentive Payment:** $1,414,021.67

### Milestone 6
- **Estimated Incentive Payment:** $2,210,047.50

### Milestone 7
**I-12.** Utilization of appropriate crisis alternatives
- **I-12.1. Metric: increase in utilization of appropriate crisis alternative (PES).**
  - Baseline: 0 visits
  - Goal: 2500 to PES in DY 4
- **c. Data source:** Claims, encounter, and clinical record data.
- **d. Rationale:** see project goals.

**Milestone 7 Estimated Incentive Payment:** $2,210,047.50

### Milestone 8
**Estimated Incentive Payment:** $1,865,361

### Milestone 9
**I-12.** Milestone: Utilization of appropriate crisis alternatives
- **I-12.1. Metric: increase in utilization of appropriate crisis alternative (PES).**
  - Baseline: 0 visits
  - Goal: 3750 visits to PES in DY 5
- **c. Data source:** Claims, encounter, and clinical record data.
- **d. Rationale:** see project goals.

**Milestone 9 Estimated Incentive Payment:** $1,865,361

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: 3,525,659</th>
<th>Year 3 Estimated Milestone Bundle Amount: $4,242,065</th>
<th>Year 4 Estimated Milestone Bundle Amount: $4,420,095</th>
<th>Year 5 Estimated Milestone Bundle Amount: $3,730,722</th>
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</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $15,918,541
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Intervention Unit (CIU)</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 136141205.1.10 – PASS 3</td>
</tr>
<tr>
<td>Performing Provider: University Hospital</td>
</tr>
<tr>
<td>Performing Provider TPI: 136141205</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** Creation of a crisis intervention unit that can provide care in a safe environment for those patients who do not require acute care admissions. By providing them with case management service in the least restrictive environment acute inpatient beds are preserved for more appropriate admissions. This will increase emergency room throughput for medical as well as mental health patients. By expanding access and providing clinical consultation, patients will be evaluated and dispositioned in a timely manner.

**Need for the project:** A gap analysis conducted in 2011 by a joint task force between University Health System (UHS), Methodist Healthcare Ministries (MHM), The Center for Health Care Services (CHCS), The University of Texas Health Science Center at San Antonio Department of Psychiatry and Methodist HealthCare System of San Antonio (MHS) identified gaps in the current crisis system & community that are resulting in emergency rooms being inundated with psychiatric patients. In 2011, University Hospital’s Psychiatric Emergency Services evaluated 3,127 patients, and of those, 1,332 (42.6%) were released home. As indicated in the RHP 6 Community Needs Assessment this project meets the regional goal to increase access to outpatient care for adults with moderate acuity behavioral health needs in order to mitigate readmissions for acute care services and the inappropriate use of emergency departments.

**Target population:** Per the 2009 Hinchman study, 3346 indigent inpatients with psychiatric diagnoses were treated in the community for that calendar year. UHS anticipates diverting 25% of those from inpatient stays through this project.

**Category 1 or 2 expected patient benefits:** This project will assure that the right care is being provided in the right setting (OD-9.3.1) and will serve patients through:

- Offering crisis stabilization services outside of the ED and inpatient settings

We intend to positively impact the current year population equivalent of the 3,346 indigent populations present in the community during 2009 through offering a crisis intervention unit service that doesn’t exist in the community today. Through this service delivery vehicle, in concert with the community-based psychiatric emergency service, we intend to materially reduce visits to the traditional emergency department and then to materially reduce readmissions to the
hospital after inpatient admissions. We will quantify this opportunity in an updated estimate of CIU visits in the community.

Category 3 outcomes: 3.IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate

- DY 4: Reduction of readmission rate by TBD for the target population
- DY 5: Reduction of readmission rate by TBD for the target population

Project Description:

A gap analysis conducted in 2011 by a joint task force between University Health System (UHS), Methodist Healthcare Ministries (MHM), The Center for Health Care Services (CHCS), The University of Texas Health Science Center at San Antonio Department of Psychiatry (UTHSCSA) and Methodist HealthCare System of San Antonio (MHS) identified gaps in our current mental health crisis stabilization system which result in hospital emergency rooms being inundated with psychiatric patients. The primary gaps identified included the lack of adequate outpatient services, the lack of adequate numbers of psychiatrists providing psychiatric inpatient care, and insufficient inpatient beds for the community (both in community hospitals and state hospitals). The recommendations made were for developing a unit to provide crisis stabilization, expansion of outpatient services, creation of an intensive outpatient treatment program, and creation of a discharge clinic. This project addresses one of these areas (crisis stabilization). In 2011, University Hospital’s Psychiatric Emergency Services evaluated 3,127 patients, and of those, 1,332 (42.6%) were released home. This latter group represents patients who might have been more appropriately evaluated in an alternative setting to the emergency room. Other communities have created units providing crisis stabilization for those patients who do not require the more expensive and less desirable setting of an emergency room or inpatient hospital admission for resolving crises. In addition, moving patients out of the hospital-based emergency room setting when such level of care is not needed diminishes overcrowding and provides more timely evaluation of those who DO require a hospital-based level of care.

This project is designed to address the needs of adult (>18 years of age) psychiatric patients in Bexar County emergency departments by expanding access to alternative behavioral health treatment settings. This project will assure that the right care is being provided in the right setting (OD-9.3.1) and includes the following components:

- Increase access to an underserved patient population by hiring additional psychiatrists, psychiatric nurse practitioners and other support staff to provide evaluations emergently with subsequent short term stabilization
- Treat both voluntary and involuntary patients in the safest and most appropriate setting by creating a Crisis Intervention Unit (CIU)

Anticipated challenges include recruitment of psychiatrists and mid-level psychiatric practitioners and financial sustainability. From a financial perspective this project addresses the underserved needs of indigent behavioral health patients in the San Antonio community. The lack of treatment resources for the indigent mental health patient is a community problem and the burden of providing care should not be the responsibility of any one health system. Developing funding streams which distribute the financial burden among other healthcare
systems in the San Antonio are essential to maintaining this service in the future.

Another challenge is the ability to recruit psychiatrists to our community since that specialty is under-represented already. Thus we anticipate using a staff model of some employed psychiatrists and mid-level providers, supplemented by contracted hourly providers, and contracted providers available through telemedicine.

As indicated in the RHP 6 Community Needs Assessment this project meets the regional goal to increase access to outpatient care for adults with moderate acuity behavioral health needs in order to mitigate readmissions for acute care services and the inappropriate use of emergency departments.

By the end of DY5, an increase in crisis stabilization services will be provided to patients currently not receiving such services. There is currently no crisis stabilization service in Bexar County for indigent patients.

**Starting Point/Baseline:**

A baseline does not exist for this project as a crisis intervention unit for indigent patients does not exist in the community today.

We anticipate that once the Crisis Intervention Unit is opened and community education to EMS, healthcare systems, and law enforcement is completed, the volume of services will increase fairly quickly. We plan to compile baseline demographic data for the first six months in reporting systems to be built with the development of this new service. Data collected should include the following:

- Number of patient visits
- Number of unduplicated patients evaluated
- Number of unduplicated patients admitted to University Hospital’s inpatient psychiatry unit
- Number of patients re-admitted within 30 days of discharge from University’s inpatient psychiatry unit to any University Hospital inpatient unit
- Identification of frequent utilizers of inpatient services who have primary or secondary behavioral health diagnoses
- Payer mix
- Length of stay
- Average daily census
- Disposition at release
- Quality indicators

**Rationale:**

The Mental Health Care Services Project conducted by Methodist Healthcare Ministries in July, 2010 identified a psychiatric shortage in San Antonio. Based on projected population growth and the national ratio of 13.9 psychiatrist/100,000 population, San Antonio currently needs 49 additional psychiatrists. In addition, psychiatrists are trending toward working in outpatient settings rather than in hospital inpatient units. Given both of these factors, local health systems have challenges providing 24/7 acute stabilization services. Development of a Crisis Intervention Unit accessible to the community, would allow for more efficient use of psychiatrists and psychiatric nurse practitioners.
In 2011, University Hospital had 987 total admissions (unduplicated) to the inpatient psychiatric unit. Of those, 172 (unduplicated) were readmitted to any service within 30 days (17%). By creating an alternative to inpatient admission for those appropriate but needing crisis intervention beyond the evaluation and stabilization provided within an emergency room, the inpatient readmission rate should decrease psychiatric services outside of the hospital will facilitate care for psychiatric patients in the most appropriate treatment setting.

This project model is based on adding to and expanding existing mental health resources and not in lieu of existing mental health services and programs in our community. Less than 33% of the state’s 48,700 practicing physicians accept Medicaid patients. That, along with the mental health provider shortage, leads to increasing the inappropriate use of emergency rooms and criminal justice systems. (RHP pg. 14)

This project is responsive to Community Need #4 (CN4) – Address the shortage of high quality integrated mental and behavioral health services in the community.

This is a new initiative for our Health System as the service doesn’t exist now.

The following core components will be addressed:

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

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

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

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

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
**Related Category 3 Outcome Measure(s):**

**IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate**

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

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

According to a 2009 American Hospital Association report approximately 18% of Medicare patients are readmitted within 30 days costing the Medicare program approximately $15 billion a year. Legislators and regulators at all levels of government are exploring options for increasing quality and reducing health care costs. While not all readmissions are avoidable, understanding what is causing them and the development of strategies to reduce them should be implemented.

A literature review of high utilizers of emergency room services for behavioral health related issues indicates that frequent users typically have clinical conditions such as alcohol or drug use. In addition, significant social barriers such as housing, lack of health insurance, poor social support and lack of transportation have been identified. One of the components of this project is the creation of a Crisis Intervention Unit that can provide care in a safe environment for those patients who do not require acute care admissions. By providing these services in the least restrictive environment acute inpatient beds are preserved for more appropriate admissions.

**Relationship to other Projects:**

The four projects for RHP 6 that relate to this project applying to the same population and geography are:

- 136141205.2.1 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions. (University Health System)
- 136141205.1.5 1.9.2 Expand access to specialty care (outpatient psychiatry) to provide follow-up after hospitalization. This same program could provide follow up after discharge from a Crisis Intervention Unit and collaborate with the Intensive Outpatient Program for continuity of care. (University Health System)
- 137251808.1.3 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system through establishment of crisis transitional residential options (32 beds), for adults. Crisis residential services are typically for voluntary patients who are not a danger to self/others and could provide a broader continuum of step-down care for the target population. (Center for Health Care Services)
- 085144601.1.6 1.14.2 Expand specialty care capacity through the Sustained Treatment as
an Outpatient Priority (STOP) Program. Establishes a clinical training program for the
treatment of Substance Use Disorders and targets behavioral health/substance abuse 30
day readmission rate. This program could provide substance abuse treatment for the
target population. (University of Texas Health Science Center)

1.13.2 Development of Psychiatric Emergency Services (University Health System).

<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camino Real Community Services proposes the development of a behavioral health crisis stabilization service with a target population outside of Bexar County (121990904.1.1, 1.13); however, sharing of experiences could serve to support a learning collaborative focused on this type of intervention to share ideas, lessons learned, and implementation strategies, successes and barriers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan for Learning Collaborative:</th>
</tr>
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<tbody>
<tr>
<td>This project is proposed through the same performing provider that serves as the anchor of the RHP6. Thus we are very invested in developing and supporting learning collaboratives. Camino Real Community Services is proposing a similar project, thus creating a natural learning collaborative opportunity between our two organizations. In addition, the Bexar County Commissioners Court Mental Health Consortium identified that the unavailability of crisis services is a gap in Bexar County and thus offers an already identified group of stakeholders who would be willing to participate in the sharing and testing of new ideas and solutions with regard to implementation and sustainability.</td>
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<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinate care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth). The project addresses community needs by improving access to care for patients in a mental health crisis who can be stabilized outside of an inpatient hospital setting.</td>
</tr>
</tbody>
</table>

This project is based on a 20 bed crisis intervention unit (CIU). The project is designed to provide services to individual’s age 18 years and above. Populations served will include individuals with mental health and/or substance abuse diagnosis. The model is based on expanding current mental health resources in our community.
### 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Intervention Unit (CIU)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>University Hospital</th>
<th>TPI - 136141205</th>
</tr>
</thead>
<tbody>
<tr>
<td>136141205.3.27</td>
<td>3.IT-3.8</td>
<td>Behavioral Health/Substance Abuse 30 day readmission rate</td>
<td></td>
</tr>
</tbody>
</table>

**Year 2**
(10/1/2012 – 9/30/2013)

**Milestone 1**
P-1. Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers.

P-1.1. Metric: Number of meetings and participants.
Goal: 2 planning meetings will be held.
Data Source: Attendance lists

Milestone 1 Estimated Incentive Payment: $3,525,659

**Milestone 2**
P-2. Conduct mapping and gap analysis of current crisis system.

**Year 3**
(10/1/2013 – 9/30/2014)

**Milestone 3**
[P-3]: Develop implementation plans for crisis services
Metric 1 [P-3.1]:
Baseline/Goal: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed based on gap analysis and assessment of needs
Data Source: Written plan

Milestone 3 Estimated Incentive Payment: $1,414,021.67

**Milestone 4**
P-4. Hire and train staff to implement identified crisis stabilization services.
P-4.1. Metric: Number of staff hired and trained.
Goal: Hire and train the

**Milestone 6**
P-6. Evaluate and continuously improve crisis services
P-6.1. Metric: Project planning and implementation documentation demonstrates plan, do, study, act or Lean quality improvement cycles
Goal: conduct 2 quality improvement cycles
a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 6 Estimated

**Year 4**
(10/1/2014 – 9/30/2015)

**Milestone 8**
P-8. Milestone: Evaluate and continuously improve crisis services
P-8.1. Metric: Project planning and implementation documentation demonstrates plan, do, study, act or Lean quality improvement cycles
Goal: conduct 2 quality improvement cycles
a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 8 Estimated

**Year 5**
(10/1/2015 – 9/30/2016)
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P-2.1</strong></td>
<td>Metric: Produce a written analysis of community needs for crisis services. Goal: Produce a written analysis of community needs for crisis services. Data Source: Written plan</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>Estimated Incentive Payment: $1,762,829.50</td>
</tr>
<tr>
<td><strong>P-5.</strong></td>
<td>Develop administration of operational protocols and clinical guidelines for crisis services. P-5.1. Metric: Completion of policies and procedures. Goal: Completion of policies and procedures for crisis services. a. Data Source: Internal policy and procedures documents and operations manual.</td>
</tr>
<tr>
<td><strong>Milestone 5</strong></td>
<td>Estimated Incentive Payment: $1,414,021.67</td>
</tr>
<tr>
<td><strong>I-12.</strong></td>
<td>Utilization of appropriate crisis alternatives I-12.1. Metric: increase in utilization of appropriate crisis alternative (CIU). Baseline: 0 visits Goal: # admissions to CIU in DY4 TBD during previously completed community needs assessment phase. c. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals.</td>
</tr>
<tr>
<td><strong>Milestone 7</strong></td>
<td>Estimated Incentive Payment: $2,210,047.50</td>
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<tr>
<td><strong>Milestone 8</strong></td>
<td>Estimated Incentive Payment: $1,865,361</td>
</tr>
<tr>
<td><strong>Milestone 9</strong></td>
<td>Estimated Incentive Payment: $1,865,361</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,525,659</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,242,065</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,918,541</strong></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,918,541</strong></td>
</tr>
</tbody>
</table>
**Identifying Project and Provider Information:**

| Title: 1.8.6 Increase and expand oral health services |
| Unique RHP ID#: 136141205.1.11 – PASS 3 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

**Project Summary:**

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** Establish an affiliated/integrated dental health services program that incorporates patient navigation within the medical home model of care by partnering with Federally Qualified Health Centers. These efforts will result in timely, accessible, integrated, and patient-centered preventive dental health care services for economically underserved populations with diabetes residing in Bexar County, Texas.

**Need for the project:** Oral diseases ranging from dental caries (cavities) to oral cancers cause pain and disability for millions of Americans (Healthy People 2020). Studies link oral health, particularly periodontal (gum) disease, to several chronic diseases that include diabetes and heart disease. Such conditions may be prevented in part with regular preventive visits to the dentist. Economically vulnerable populations that include minority adults, persons with a chronic disease are also significantly less likely to have access to oral health care compared to their non-poor and non-minority peers. For example, a recent survey conducted on leading oral health indicators found that less than half (44.5%) of eligible individuals have had a dental visit within the past 12 months. (Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, 2007).

In Bexar County, Texas, 22% of the 1.7 million residents live at or below the poverty level ($22,557), 17% receive no medical care due to cost, and 21% have no form of health insurance coverage. Recent health assessments of the population find that residents with less than a high school education and an annual household income of less than $15,000 are significantly less likely to rate their oral health status as good to excellent (25% and 20%, respectively). In addition, Hispanics and African-Americans and individuals living in the Southeast and Southern regions of the county were less likely to rate their oral health status good to excellent or report having adequate dental health coverage (Bexar County Health Collaborative, 2010).

**Target population:** Our target population will be Carelink enrollees diagnosed with diabetes that seek services at UHS including patient centered medical homes and or who receive services at our FQHC partner sites.

**Category 1 or 2 expected patient benefits:** This project seeks to provide the following components:
- Reduce/close disparities in access to preventive dental health services in underserved populations
- Increase awareness among the target population on the importance of oral health to overall health and well-being

**Category 3 outcomes:** IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services (*Standalone measure*)

- DY4: Improvement Target: Increase in chronic disease patients who access dental health services TBD% from baseline
- DY5: Improvement Target: Increase in chronic disease patients who access dental health services TBD% from baseline

**Project Description:**

In the United States, safety-net hospitals remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. The passage of the Affordable Care Act in 2010 marked an important legislative commitment to addressing rising health care costs and improving access to quality healthcare for all Americans. To ensure implementation of healthcare reform, safety-net hospitals will remain critical to responding to the mandate of providing preventive health care services to economically vulnerable populations within a model of healthcare delivery that is accessible, integrated, and patient-centered.

University Health System (UHS) proposes to partner with local safety net providers that include Federally Qualified Health Centers (FQHCs) to establish timely, accessible, integrated, and patient-centered preventive dental health care services for economically vulnerable populations residing in Bexar County, Texas.

This project will increase and expand access to preventive oral health care within the UHS medical home model of care by collaborating with FQHCs alongside patient navigation to ensure that patients adhere to their recommended dental treatment plan.

This collaboration will result in the establishment of dental health services at the Texas Diabetes Institute, which is one the nation's largest and most comprehensive centers, entirely dedicated to diabetes prevention, treatment, education and research.

In an effort to strengthen delivery of patient-centered care for persons with diabetes, delivery of preventive dental health services will be made possible by having a patient navigator work closely with board-certified endocrinologists and or their primary care provider and related diabetes specialists to ensure timely receipt of this service. These services will compliment in what is considered to be a firmly robust clinical treatment and prevention model of diabetes care that includes: family physicians, endocrinologists, renal specialists, orthopaedists, ophthalmologists, dermatologists, podiatrists, and wound care specialists.

Expansion of preventive dental health services will also occur through development of an additional two (2) sites at FQHC partner locations. A patient navigation model will also be incorporated within this preventive dental health care delivery design to ensure that patients adhere to receive care in a timely manner.
The primary patient population includes individuals diagnosed with diabetes and enrolled in CareLink; a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

Community Medicine Associates (the UHS owned provider group) is the primary care access point for University Health System patients, and there is currently a need for establishing clinical linkages that reduce disparities in oral health care by expanding dental health services infrastructure that currently reside within partner safety net providers (FQHCs). This will primarily occur by establishing a memorandum of understanding (MOU) to expand timely access to preventive dental health services and establish a dental health service referral process.

**Goals and Relationship to Regional Goals**

Project goals are to strengthen the health care infrastructure of the region by enhancing access to preventative oral health services and thereby addressing the regional goals of reducing gaps in access to care. Further, project goals will strongly coincide with regional goals as followed: improve health care infrastructure to better serve both Medicaid and uninsured residents of RHP 6, reduce healthcare disparities, further develop and maintain a coordinated care delivery system, and improve outcomes while containing cost growth.

**Specific Project Goals:**

- Reduce/close disparities in access to preventive dental health services in underserved populations with diabetes
- Increase awareness among the target population on the importance and relationship of oral health to overall health and well-being

**Challenges**

Challenges to this project will be the integration and coordination of preventive oral health services between University Health System and partner safety net providers (FQHCs) to (1) ensure timely receipt of care by patients, (2) ensure appropriate infrastructure (electronic medical record systems), (3) the coordination and capacity (providers, hours of operation and clinical space) to appropriately accommodate increased volume from newly established referral pathways, including CareLink. In an effort to proactively address these challenges strategic planning and assessment will be undertaken that includes meeting with key stakeholders to ensure that a balance is maintained between resources, capacity and projected demand. This is considered essential to providing care at the right time and in the right setting.

**5-Year Expected Outcome for Provider and Patient**

University Health System expects to see improvements in clinical linkages (integration and coordination of health services), well established referral pathways (primary care to dental provider) and an established infrastructure delivery of oral health services between UHS, FQHCs and the target population. The anticipated 5 year goal is to increase the proportion of
economically vulnerable individuals with diabetes that access quality dental health services following a referral from a primary care/medical provider.

### Starting Point/Baseline:
Currently, an affiliated/integrated dental health services program with partner FQHCs does not exist for patients at University Health System. Therefore, the baseline for number of participants as well as the number of participating dental providers ending on September 30, 2013 is zero (0).

### Rationale:
The National Institute of Medicine’s Committee on Access to Oral Health Services finds that almost half of all Americans do not visit a dentist each year and nearly one-third lack access to basic preventive and primary oral health care services. Published studies on disparities in access to oral health care also find that individuals who are least likely to access preventive oral health care are more likely to have higher rates of oral disease. In particular, economically vulnerable populations, including minority children, are significantly less likely to have access to oral health care compared to their more affluent and non-minority peers. Disparities in access to preventive and primary oral health care are primarily associated with factors such as education level, income, race and ethnicity, the high costs of care, and the uneven geographic distribution of dental providers (Committee on Oral Health Access to Services; Institute of Medicine and National Research Council, July 2011; Healthy People 2020).

The Patient Protection and Affordable Care Act (ACA) aims to expand delivery of preventive care to large segments of the population through expansion of healthcare coverage and cost-reduction measures that will make access to preventive oral health more accessible and affordable. Expansion of preventive care through ACA also coincides with national oral health goals for Americans that include: increasing awareness of the importance of oral health to overall health and well-being, increasing acceptance and adoption of effective preventive interventions, and reducing disparities in access to effective preventive and dental health services (Healthy People 2020).

In Bexar County, Texas, 22% of the 1.7 million residents live at or below the poverty level ($22,557), 17% receive no medical care due to cost, and 21% have no form of health insurance coverage. Recent health assessments of the population find that residents with less than a high school education and an annual household income of less than $15,000 are significantly less likely to rate their oral health status as good to excellent (25% and 20%, respectively). In addition, Hispanics and African-Americans and individuals living in the Southeast and Southern regions of the county were less likely to rate their oral health status good to excellent or report having adequate dental health coverage (Bexar County Health Collaborative, 2010).

Demand in access to timely preventive and primary oral health care in the population will be driven by demographic changes with respect to race/ethnicity, educational attainment, and age. The Bexar County population is relatively young (median age of 32 years) in comparison to the national average (median age of 37 years) and is considered a minority-majority county; 59% of county residents are Hispanic, of which 80% are of Mexican descent. It is projected that the Hispanic population in this area will grow by 45% by the year 2040 (Office of the State...
This project directly addresses:

**CN. 1 – Improve quality of healthcare delivery and patient experience**

**CN.3 – Address the lack of medical and dental health services in the community due to lack of health insurance and provider shortages**

The current health service infrastructure does not fully allow for timely access to preventive oral health services. This newly proposed initiative will invest in the expansion and enhancement of infrastructure to provide quality preventive oral health care access to the underserved of Bexar county. Proposed efforts are considered a new health system initiative that will seek to leverage existing resources with FQHCs partners to increase, expand, and enhance clinical capacity that reduce gaps in access to dental health services and help to improve the health status of residents of Bexar County, Texas.

Continuous quality improvement strategies will include assessing our clinical workflow to reduce wait times, assure timely scheduling of appointments, provide data systems to support population health management, establish effective navigation coordination, and support patient self-care, development, and accountability, and develop performance reporting and improvement plans using LEAN concepts to identify and reduce waste.

**Related Category 3 Outcome Measure(s):**

**IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services (Standalone measure)**

- **a)** Numerator: Number of chronic disease patients who access dental services
- **b)** Denominator: Total number of referrals for dental services for chronic disease patients by a health provider
- **c)** Data Source: EHR, Claims
- **d)** Rationale/Evidence: National studies on disparities in receipt of oral health services find that almost half of all Americans do not visit a dentist each year and nearly one-third lack access to basic preventive and primary oral health care services. Published studies on disparities in access to oral health care also find that individuals who are least likely to access preventive oral health care are more likely to have higher rates of oral disease. In particular, economically vulnerable populations that include minority adults and children are significantly less likely to have access to oral health care compared to their non-poor and non-minority peers. Studies on adherence to preventive oral health services find that patients are more likely to seek dental services when the importance of need is documented by a formal referral being made.

**Relationship to other Projects:**

No other projects proposed by University Health System currently.

**Relationship to Other Performing Providers’ Projects in the RHP:**

This Project is Related to the Following Other Performing Providers’ Projects:
085144601.1.12 – Increase, Expand, and Enhance Dental Services (UTHSCSA): Establish an emergency dental clinic for treating patients presenting with urgent dental conditions, including oral infections, abscesses, pain and fractured dental restorations.

0913089-02.1.1 – San Antonio Metropolitan Health District: Expand Community-Based prevention programs that provide access to early diagnosis, fluoride varnish and dental sealants to serve additional children with unmet dental needs.

**Plan for Learning Collaborative:**

This project fully lends itself to participation in an RHP-wide learning collaborative with other Performing Providers in RHP6 to develop or enhance preventive oral health/dental health services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve dental care access.

**Project Valuation:**

Project valuation for enhancing access to preventative oral health/dental health services directly responds to waiver goals including the triple aim and improving the health delivery infrastructure to better serve the Medicaid and uninsured residents of the community and region. This includes providing care in the right setting at the right time and enhancing the ability to prevent and/or treat disease earlier in the course of illness, both of which may contribute to avoidance of unnecessary admissions.

The project also addresses community need by responding to gaps in delivery of basic medical and dental services due a high percentage of the population being uninsured and limited access to providers.

Additionally, pertaining to oral health, studies have found that certain chronic diseases, such as cardiovascular disease, diabetes, obesity and stroke, are associated with dental disease after controlling for common risk factors (Griffin et al., 2009). Therefore, providing timely access to vulnerable/undeserved populations in a coordinated and integrated method can improve health status, experience, and overall quality of care delivered.

The project is considered large in scope as it looks to increase outreach to the targeted population and thereby increase the number of patients who receive needed preventive oral health care, thus reducing cost and avoidable hospitalizations.

Relative to other projects, the proposed efforts are large in scale and will require investment in human resources, technology, and organizational priorities that strengthen the opportunity to deliver integrated and accessible care to the target population.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
</table>
| **Milestone 1**  
(P-X): Conduct assessment that incorporates community needs, review of best practice and strategies to ensure that intervention is tailored to local context.  
Metric 1 (P-X.1): Documentation of assessment/literature review and strategies identified as integral to ensuring success of intervention.  
Baseline: 0  
Goal: One (1) white paper that describes needs best practices, recommendations and strategies for successful delivery of primary/preventive dental health services.  
Documentation: Documentation will include literature review, resources and community context. | **Metric 1**  
(P-4.1): Number of additional clinics, expanded space, or existing available space used to capacity.  
Goal: Establish two (2) dental care service sites.  
Documentation: Documentation of expansion or efficient use of space in support of primary/preventive health dental health sites.  
Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with clinical partners. | **Metric 1**  
(P-4.1): Number of additional clinics or expanded space  
Goal: Establish one (1) – primary/preventive dental care service site.  
Documentation: Documentation of implementation plans, services provided in support of dental health services.  
Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with clinical partners. | **Metric 1**  
(P-4.1): Number of additional clinics or expanded space  
Goal: Establish one (1) – primary/preventive dental care service site.  
Documentation: Documentation of implementation plans, services provided in support of dental health services.  
Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with clinical partners. |
| **Milestone 4**  
(P-4): Establish additional/expand existing/relocate dental care clinics or space. | **Milestone 7**  
(P-4): Expand dental care services to an additional facility  
Metric 1 (P-4.1): Number of additional clinics or expanded space  
Goal: Establish one (1) – primary/preventive dental care service site.  
Documentation: Documentation of implementation plans, services provided in support of dental health services.  
Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with clinical partners. | **Milestone 9**  
(I-X) Increase dental care volume of visits and evidence of improved access for patients seeking services.  
Metric (I-X.1): Total number of visits for reporting period.  
Baseline: October 1, 2011 to September 30, 2012 (0)  
Goal: (570) Number of dental visits for reporting period. (570) above baseline of DY 2 (0)  
Data Source: Dental EMR, referrals and activity reports  
Milestone 9 Estimated Incentive Payment: $1,246,366 |  
| **Milestone 7**  
(P-4): Establish additional/expand existing/relocate dental care clinics or space.  
Metric 1 (P-4.1): Number of additional clinics or expanded space  
Goal: Establish one (1) – primary/preventive dental care service site.  
Documentation: Documentation of implementation plans, services provided in support of dental health services.  
Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with clinical partners. | **Milestone 9**  
(I-X) Increase dental care volume of visits and evidence of improved access for patients seeking services.  
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Baseline: October 1, 2011 to September 30, 2012 (0)  
Goal: (570) Number of dental visits for reporting period. (570) above baseline of DY 2 (0)  
Data Source: Dental EMR, referrals and activity reports  
Milestone 9 Estimated Incentive Payment: $1,246,366 | **Milestone 9**  
(I-X) Increase dental care volume of visits and evidence of improved access for patients seeking services.  
Metric (I-X.1): Total number of visits for reporting period.  
Baseline: October 1, 2011 to September 30, 2012 (0)  
Goal: (570) Number of dental visits for reporting period. (570) above baseline of DY 2 (0)  
Data Source: Dental EMR, referrals and activity reports  
Milestone 9 Estimated Incentive Payment: $1,246,366 |  

**Related Category 3 Outcome Measure(s):**  
136141205.3.28  
3.IT-7.8  
Chronic Disease Patients Accessing Dental Services
<table>
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<tr>
<th>Milestone 1 Estimated Incentive Payment: $256,236.33</th>
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**Milestone 2**
(P-X): Engage stakeholders, identify resources and potential partnerships, and develop intervention plan (including implementation, evaluation and sustainability). Engage stakeholders, identify resources and potential partnerships, and develop primary/preventive dental health plan.


Goal: One (1) Memorandum of Understanding with FQHC partner detailing resources, capacity, implementation plan and

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<tr>
<th>Milestone 4 Estimated Incentive Payment: $328,691.33</th>
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**Milestone 5**
(I-X) Increase dental care volume of visits and evidence of improved access for patients seeking services.

Metric (I-X.1): Total number of visits for reporting period.

Baseline: October 1, 2012 to September 30, 2013 (0)

Goal: (300) Number of dental visits for reporting period. (300) above baseline of DY 2 (0)

Data Source: Dental EMR, referrals and activity reports

Milestone 5 Estimated Incentive Payment: $328,691.33

<table>
<thead>
<tr>
<th>Milestone 7 Estimated Incentive Payment: $550,108.50</th>
</tr>
</thead>
</table>

**Milestone 6**
(P-X): Assess efficacy of processes in place and recommend process improvements to implement, if any. Metric (P-X.1) Performing provider review and prioritization of areas or processes to improve upon. Documentation of process improvement implementation in

<table>
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<tr>
<th>Milestone 8 Estimated Incentive Payment: $550,108.50</th>
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</thead>
</table>

**Milestone 8**
(I-X) Increase dental care volume of visits and evidence of improved access for patients seeking services.

Metric (I-X.1): Total number of visits for reporting period.

Baseline: October 1, 2012 to September 30, 2013 (0)

Goal: (480) Number of dental visits for reporting period. (480) above baseline of DY 2 (0)

Data Source: Dental EMR, referrals and activity reports

Milestone 8 Estimated Incentive Payment: $550,108.50
sustainability in support of primary/preventive dental health service delivery.

Documentation: Agreed upon Memorandum of Understanding with Partner FQHC for dedication of clinical space for primary/preventive dental health service delivery.

Data Source: Memoranda of Understanding, Oral Health Services expansion proposal/agreements with partner FQHCs.

Milestone 2 Estimated Incentive Payment: $256,236.33

**Milestone 3**
(P-X): Conduct staff training related to MoU and referral plan for DY3

Metric 1 (P-X.1): Conduct training sessions that orient staff on implementation including referral protocol in support of MoU milestone in support of DY3

Goal: One training session addressing MoU deliverables for DY3

Data Source: Report of process identified areas of improvement and process improvement implementation.

Milestone 6 Estimated Incentive Payment: $328,691.33
<table>
<thead>
<tr>
<th>Documentation: Documentation of planning for training, training materials and sign-in sheets.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Training agenda, sign-in sheet, training material</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $256,236.33</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $768,709 | Year 3 Estimated Milestone Bundle Amount: $986,074 | Year 4 Estimated Milestone Bundle Amount: $1,100,217 | Year 5 Estimated Milestone Bundle Amount: $1,246,366 |
|---------------------------------------------------------------|

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,101,366**
### Identifying Project and Provider Information:

- **Title:** 1.2.2 - Increase the number of primary care providers and other clinicians/staff: Improving Rural Access to Primary Care  
- **Unique RHP ID#:** 121782003.1.1 – PASS 1  
- **Provider Name:** Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital (UMH)  
- **TPI:** 121782003

### Project Summary:

- **Provider Description:** Uvalde Memorial Hospital is a 66-bed sole community hospital located in Uvalde, TX serving approximately 47,000 individuals residing within 5 counties (7,000 square mile area).

- **Intervention(s):** This project will increase primary care capacity while decreasing potentially preventable readmissions by recruiting new primary care physicians and by training community health workers.

- **Need for the project:** Currently there only 9 primary care physicians serving our 5 county service region. 32% of residents within these counties are uninsured. Our current primary care provider shortage combined with our high percentage of uninsured has caused our ED volume to steadily increase. This problem is exacerbated by 30 day readmissions and ED “frequent flyers”.

- **Target population:** The target population includes: ED patients with non-emergent conditions, patients discharged with a high risk for readmission, patients without a primary care provider, and patients in need of enhanced follow-up post discharge. Our hospital operates with a Medicaid inpatient utilization rate higher than 50% and a low income utilization rate also higher than 50%.

- **Category 1 or 2 expected patient benefits:** The project seeks to recruit at least 4 new primary care providers to our service region. At the end of DY 4, the combined patient panels of primary care providers recruited in DY 2, 3 and 4 is expected to at least total 2,600 patients. This should result in between 5,200 and 7,800 combined patient visits. With the conclusion of DY 5, the combined patient panels of new primary care providers is expected to at least total 4,600 patients. This should result in between 9,200 and 13,800 combined patient visits. Also, the project aims to train 8 new community health workers (CHWs) by the end of DY 5. In DY 4 and DY 5, CHWs trained and selected for employment at UMH will ensure that 100 (DY 4) and 150 (DY 5) additional patients receive care under the Chronic Care Model for targeted chronic diseases or for MCC. The will achieve this by working alongside and communicating with RNs, case managers and physicians. These CHWs will enhance the continuum of care while assisting primary care providers and case managers to reduce preventable readmissions and ED visits for target conditions.

- **Category 3 outcomes:** IT-9.2 Our goal is to reduce ED visits for target conditions (CHF, Diabetes, Cardiovascular Disease/Hypertension, and Chronic Obstructive Pulmonary Disease). Percent reduction TBD in DY 3.  
  IT-3.1 Our goal is to reduce the all cause 30-day readmission rate. Percent reduction TBD in DY 3.
Project Description:

Uvalde Memorial Hospital proposes to improve access to primary care within our rural service region through expanding capacity and a community health worker training program.

The need for additional primary care providers, who serve our low income border county population (70% Hispanic), has never been more pressing. Most, if not all of the local PCPs within our 5 county service region, are not accepting new patients. This has resulted in a high volume of patients who rely on the UMH emergency department for primary care. A high volume of patients with non-emergent conditions strains Emergency Department (ED) staff and physicians whose primary role is caring for acute, emergency conditions. In addition, many patients without a primary care physician delay treatment until their health has deteriorated substantially.

When the appropriate level of care is matched to the appropriate setting, high quality health care is more likely to occur. An emergency room is not the appropriate setting within which to treat patients in need of primary care. Improving rural access to primary care will alleviate this burden placed on ED staff and physicians while reducing cost to the patient, the payer and the hospital. Most importantly, it will result in a higher quality of care for patients. UMH will improve rural access to primary care in our service area by combining two approaches.

First, UMH will conduct a primary care gap analysis to determine workforce shortage areas. UMH will expand local primary care capacity by recruiting at least 4 new primary care physicians (1 per year) and/or 4 new mid-level providers (1 per year) within the identified shortage area(s).

Next, UMH will begin and expand primary care training for case managers and community health workers. In DY 2, UMH will establish a community health worker (CHW) training program. At least 3 CHWs will complete the program by the end of DY 3. This program will involve training in the Chronic Care Model. In DY 3 UMH will conduct a pilot test of the case management/community health worker program within Uvalde. This pilot test will include CHW involvement in quality improvement projects. The CHW training program will grow in class size from DY 3 – DY 5. CHW training program assessment scores and satisfaction scores will also be tracked and improved upon in DY 4 and DY 5.

Goals and Relationship to Regional Goals:

The goal of this project is to use community health workers (CHWs), case managers and primary care physicians/mid-levels to improve access to and utilization of primary care. CHWs will be supervised by case managers and will focus on enhanced care coordination and culturally competent care to high-risk patients.

Project Goals:

- A reduced number of patients who utilize the ED for primary care
- Patients with chronic disease(s) who are well educated with respect to managing their condition(s) and health appropriately
- A substantial decrease in the rate of potentially preventable re-admissions
- Greater access to and utilization of local primary care providers

This project meets the following regional goals:

- Work together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered care, in the most effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
- Further develop and maintain a coordinated care delivery system.
- Improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents through its primary care capacity expansion in workforce shortage areas. The project develops and maintains a coordinated care delivery system through its CHW training program. The project improves outcomes while containing cost growth through reducing ED admissions for target conditions and reducing all-cause 30 day readmissions.

**Challenges:**

A major challenge this project will face will be recruiting primary care physicians and/or mid-levels to an extensively rural service area. However with appropriate incentives and recruiting strategies, UMH believes can overcome this challenge. Additional challenges will be establishing trust between patients and CHWs; and establishing trust between primary care physicians and CHWs. Through proper communication and education regarding the intent of the program, UMH will overcome this challenge.

**5-Year Expected Outcome for Provider and Patients:**

UMH plans to see improvements in 30 day readmission rates, ED admissions and in the overall continuum of care. The service region and population will see much greater access to primary care with a focus on management of chronic conditions through CHW and primary care provider communication. The population will also be more educated on managing their health appropriately through the use of CHWs in the community.

**Starting Point/Baseline:**

Baseline for primary care capacity expansion will be established by the primary care gap analysis conducted in DY 2. Currently there are 9 primary care physicians serving patient within the UMH 5 county service region. This baseline will shift every year, based on the accomplishments achieved in the prior year. Baseline for the community health worker training program will be established in DY 2 when the program begins.

**Rationale:**

The executive committee of UMH, as well as its governing board, took time to identify needs of our rural population and create various projects addressing these needs. “Improving Rural Access to Primary Care” was chosen out these projects. It was determined to be the most likely to have the greatest impact on the health of our population. This project fit within the project option area 1.2.2 because it not only mentions increasing the number of primary care providers but it also specifically mentions increasing the number of community health workers/promotoras, an important piece of our project.

The CHWs trained throughout the project will have close ties to the community. These CHWs will be bi-lingual and possess cultural skills needed to connect with patients in our underserved, low-income community. CHWs will be:

- Compassionate, sensitive, and culturally attuned to the people and community
- Knowledgeable about the environment and healthcare system
- Connected with critical decision makers inside the system

The primary functions of CHWs employed by the hospital, after completing the training program, will be to educate and motivate patients to: follow their discharge instructions, take their medications consistently and attend their appointments with physicians. They may also assist patients overcome common rural barriers such as: transportation, lack of insurance, and lack of health knowledge/literacy. Under the supervision of the case manager, the CHWs will
perform these functions in a non-threatening, simple manner that wins their trust. These CHWs will be assigned to high-risk patients and ED “frequent flyers” to reduce 30 day PPRs and ED admissions for target conditions (see Cat. 3 selected outcomes). However, these goals would be unrealistic if primary care capacity was not being expanded throughout the project. Improvement milestone (I-X) was created and inserted into the project to provide needed access to primary care for rural patients. Currently, the primary care capacity shortage in our community makes efforts to shift care from an acute care mentality to prevention/chronic disease management mentality extremely difficult, if not impossible. An increased capacity combined with a line of communication between CHWs, case managers and primary care physicians/mid-levels will reduce ED admissions and 30 day readmissions. This project will give us the resources and training to make this shift in focus to prevention and chronic disease management feasible and realistic.

Unique community need identification numbers the project addresses:
- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.2 – A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patient with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer and diabetes.
- CN.3 – Many residents in RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently UMH does not have a case management or a community health worker training program. Also, most if not all local primary care physicians are not accepting new patients. This has created a high demand by patients for primary care services. This project will reduce patients’ reliance on the UMH emergency room for primary care. It will also lower potentially preventable re-admissions. As there is not currently a case management program, a baseline for all cause potentially preventable re-admissions will be established in DY 2.

Related Category 3 Outcome Measure(s):

| OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) |
| IT-3.1 All cause 30 day readmission rate- NQF 1789 (stand-alone) |
| • Cohort (1): admissions to acute care facilities for patients aged 65 years or older |
| OD-9: Right Care, Right Setting |
| IT-9.2 ED appropriate utilization (stand-alone) |
| • Rate: ED admissions for target conditions (Congestive Heart Failure-CHF, Diabetes, Cardiovascular Disease/Hypertension, Chronic Obstructive Pulmonary Disease-COPD) |

Reasons/rationale for selecting the outcome measures:
These outcome domains with their associated improvement targets were chosen after considering the outcomes most likely to be impacted the most by the project. These outcomes are also a priority for RHP 6 because they directly related to CN.1, CN.2 and CN.3 in the RHP community needs assessment.

An example given in a review of literature of CHW success was found at CHRISTUS Spohn Health System in Corpus Christi, TX. As a result of their CHW pilot study, CHRISTUS
estimated a $56,000 savings to the hospital per ED assigned a CHW per year. While the UMH program “Improving Rural Access to Primary Care” has substantial differences, we anticipate a similar or greater impact on ED usage and costs.

Our program will reduce PPRs through case management that utilizes CHWs with an open line of communication with PCPs. Increasing the number of PCPs alongside this case management/CHW program is vital as there is a severe shortage of PCPs in the region currently. All 5 counties within the UMH service area are currently designated as primary health care professional shortage areas (HPSAs). This project will lower patient cost of care (important for a low-income population) through reducing re-admission rates and educate patients on the benefit of primary care over emergency department care. CHWs will help patients overcome common local barriers to primary care: transportation, insurance coverage, income, culture and education.

Relationship to other Projects:

This project is related to other primary care capacity and primary care training projects [1.1, 1.2]. It focuses on expanding primary care capacity while training community health workers and case managers. This project will “improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region” while “improving outcomes and containing cost growth” both of which are RHP 6 goals. Examples of projects of other providers that are related: University Hospital 136141205.1.2, UTHSCSA [TPI].1.2

Related Category 4 Population-focused measures.

RD-2: 30-day readmissions
RD 4: Patient-centered Healthcare
RD 5: Emergency Department

Relationship to Other Performing Providers’ Projects in the RHP:

University Hospital, PA: 1.2
Uvalde Memorial Hospital, PA:1.2
UTHSCSA, PA: 1.2
Medina Regional Hospital, PA: 1.1
Frio Regional Hospital, PA: 1.1
Val Verde Regional Medical Center, PA: 1.1

Plan for Learning Collaborative:

UMH plans to participate in an RHP-wide learning collaborative with other providers with similar projects. RHP 6 is committed to transforming health care in our region and throughout the state. Given the large number and value of projects proposed for our region, University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives.

UMH plans to be a significant part of a learning collaborative with other performing providers with similar projects, as outlined above by the RHP 6 anchor, University Health System. This may include a quarterly newsletter distributed the other providers concerning progress towards goals and lessons learned. Meeting semi-annually or more regularly is also being considered.

Project Valuation:

Out of all potential DSRIP projects considered, UMH has chosen “Increase the number of primary care providers and other clinicians/staff: Improving Rural Access to Primary Care”. This project received a score of 5 on a scale of 1-5 in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment. UMH also assessed projects based on cost avoidance to the payer, in addition to valuing potential projects
based on these 4 areas. “Improving Rural Access to Primary Care” was high on the list of projects with the most costs avoided. A more detailed look at how UMH valued the project based on cost avoidance follows.

**Cost Avoidance - “Improving Rural Access to Primary Care”**:

Based on research conducted, it was estimated that 1 primary care provider covers 1,900 lives. From this number, it was estimated that for each primary care physician added, a corresponding 20 ER visits/month decrease would occur by DY 5. Also, a reduction in the amount Medical/Surgical department admissions of 10/month by DY 5 would occur for each PCP added. The average cost of an ER visit is $1,318 per visit. The average cost of a Med/Surg. department admission is $5,359. The total cost avoidance by the end of DY 5 using these figures is:

- **DY 2**: $643,080
- **DY 3**: $1,286,160
- **DY 4**: $1,929,240
- **DY 5**: $2,572,320

$6,430,800 + $1,611,992 (est. investment) = **8,042,792**

Est. investment = cost of primary care physician recruitment, case management/CHW program

This cost avoidance number, $6,430,800, is only cost avoided to the payer. It does not include costs avoided by the patient. Also, this amount does not include estimated costs to be saved as a direct or indirect result of the community health worker training program. Costs will be reduced further by decreasing potential preventable 30-day readmissions and ED utilization from this program. A valid estimate of the cost avoidance for this community health worker program has not been determined at this time. However, UMH anticipates this cost avoidance to be significant.

When the cost avoidance and the project investment are totaled the potential value of the project has a variance of $277,340 from the Total DSRIP funding allocated to Cat. 1.2 projects $8,320,096. This variance however will be more than accounted for when the cost avoidance of the case management/CHW program is accounted for. The cost avoidance figures above assume primary care capacity expansion will occur at a rate of 1 new physician per year. However, if capacity expansion occurs at rate greater than this, it would greatly increase the cost avoidance of the project.

**References**

1. Agency for Healthcare Research and Quality Medical Expenditure Panel Survey: Emergency Services
2. Texas Health and Human Services Commission, Potentially Preventable Readmissions in the Texas Medicaid Population Fiscal Year 2010
<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Year</th>
<th>Outcome Measure(s)</th>
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<th>Outcome Measure(s)</th>
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<th>Outcome Measure(s)</th>
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<tbody>
<tr>
<td>2</td>
<td>121782003.1.1</td>
<td>3</td>
<td>121782003.3.1</td>
<td>4</td>
<td>121782003.3.1</td>
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<tr>
<td>2</td>
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<td>3.1T-3.1</td>
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<td>3</td>
<td>3.1T-9.2</td>
<td>4</td>
<td>All cause 30 day readmission rate- NQF 1789</td>
<td>5</td>
<td>ED appropriate utilization</td>
</tr>
</tbody>
</table>

**Milestone 1**

**[P-1]** Conduct a primary care gap analysis to determine workforce needs.

**Metric 1** [P-1.1]: Gap assessment of workforce shortages

Baseline: Currently there are 9 active primary care physicians, baseline for other documented gaps in primary care established through gap assessment. 0, or no CHW, case management or primary care provider training program currently exists.

**Goal:** Submission of completed assessment.

**Data Source:** Assessment results

**Milestone 4**

**[P-3]** Expand positive primary care exposure for residents/trainees

**Metric 1** [P-3.2]: Train trainees in the Chronic Care Model

Baseline: 0, There is not currently a Chronic Care Model training program for primary care trainees at UMH

**Goal:** Documentation of program

**Data Source:** Curriculum, rotation hours, and/or patient panels assigned to resident/trainee

**Milestone 4 Estimated Incentive Payment:** $739,952.67

**Milestone 7**

**[I-11]** Increase primary care training and/or rotations

**Metric** [I-11.1]: 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, and/or other clinicians/staff (e.g. health coaches, community health workers/promotoras).

Baseline: 3 primary care trainees, i.e. baseline established by DY 3 goal achievement.

**Goal:** A 100% increase in class size from DY 3 baseline, i.e. double class size from 3 to 6.

**Milestone 10**

**[I-11]** Increase primary care training and/or rotations

**Metric** [I-11.1]: 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, and/or other clinicians/staff (e.g. health coaches, community health workers/promotoras).

Baseline: 6 primary care trainees, i.e. baseline established by DY 4 goal achievement.

**Goal:** A 25% increase in class size from DY 4 baseline, i.e. increase class size from 6 to 8.
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 5</th>
<th>Milestone 7</th>
<th>Milestone 10</th>
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<tbody>
<tr>
<td>Estimated Incentive Payment: $678,266.67</td>
<td>[I-11]: Increase primary care training and/or rotations</td>
<td>Estimated Incentive Payment: $742,103.6</td>
<td>Estimated Incentive Payment: $613,042.3</td>
</tr>
</tbody>
</table>

**Milestone 2**

[P-2] Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists and others.

**Metric 1 [P-2.1]**: Expand the primary care residency, mid-level provider, and/or other clinician/staff (e.g., health coaches, community health workers/promotoras) training programs and/or rotations

**Baseline**: 0, There is not currently any primary care training programs at UMH.

**Goal**: Documentation of applications and agreements to expand training programs.

**Data Source**: Training program documentation

**Milestone 2 Estimated Incentive Payment**: $739,952.67

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**Milestone 6**

**Goal**: A 300% increase in class size from DY 2 baseline, i.e. triple class size from 0 or 1 to 3.

**Data Source**: Documented enrollment by class by year by primary care training program

**Milestone 5 Estimated Incentive Payment**: $739,952.67
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<thead>
<tr>
<th>Milestone 3</th>
<th>Milestone 9</th>
<th>Milestone 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>[I-X] Increase primary care capacity within workforce shortage area(s)</td>
<td>[I-X]: Increase primary care capacity within a workforce shortage area(s)</td>
<td>[I-X]: Increase primary care capacity within a workforce shortage area(s)</td>
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<tr>
<td>Metric: [I-X.1]: Increase primary care capacity within workforce shortage area(s) as identified by primary care gap analysis [P-1]. Numerator: Sum of new primary care providers within shortage areas. Denominator: Sum of primary care providers practicing in DY 2 within shortage area(s). Baseline: There are currently 9 practicing primary care physicians. However, baseline will be set after primary care workforce shortage area(s) are identified, [P-1]</td>
<td>Metric: [I-X.1]: Increase primary care capacity within workforce shortage area(s) as identified by primary care gap analysis [P-1]. Numerator: Sum of new primary care providers within shortage areas(s). Denominator: Sum of primary care providers practicing in DY 3 within shortage area(s). Baseline: There are currently 9 practicing primary care physicians. However, baseline will be set after primary care workforce shortage area(s) are identified, [P-1]</td>
<td>Metric: [I-X.1]: Increase primary care capacity within workforce shortage area(s) as identified by primary care gap analysis [P-1]. Numerator: Sum of new primary care providers within shortage area(s). Denominator: Sum of primary care providers practicing in DY 2 within shortage area(s). Baseline: There are currently 9 practicing primary care physicians. However, baseline will be set after primary care workforce shortage area(s) are identified, [P-1]</td>
</tr>
<tr>
<td>Goal: Increase primary care capacity by recruiting at least 1 new primary care physician and/or 1 new mid-level primary care providers (physician assistant and/or nurse practitioner) within the identified shortage area(s). Data Source: Hospital reports, policy, contract or other documentation</td>
<td>Goal: Increase primary care capacity by recruiting at least 1 new primary care physician and/or 1 new mid-level primary care providers (physician assistant and/or nurse practitioner) within the identified shortage area(s). Data Source: Registry</td>
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</tr>
<tr>
<td>$678,266.67</td>
<td>Milestone 8 Estimated Incentive Payment: $742,103.6</td>
<td>Milestone 11 Estimated Incentive Payment: $613,042.3</td>
</tr>
<tr>
<td>$742,103.6</td>
<td>Milestone 12</td>
<td>Milestone 12</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $678,266.67</td>
<td>Milestone 6 Estimated Incentive Payment: $739,952.67</td>
<td>Milestone 9 Estimated Incentive Payment: $742,103.6</td>
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<tr>
<td>assistant and/or nurse practitioner) within the identified shortage area(s). (Combined patients panels for new providers recruited in DY 2 and DY 3 should reach 2,600 patients by end of DY 4. This should result in between 5,200 and 7,800 combined patient visits.) Data Source: Hospital reports, policy, contract or other documentation</td>
<td>care providers (physician assistant and/or nurse practitioner) within the identified shortage area(s). (Combined patients panels for new providers recruited in DY 2, DY 3 and DY 4 should reach 4,600 patients by end of DY 5. This should result in between 9,200 and 13,800 combined patient visits.) Data Source: Hospital reports, policy, contract or other documentation</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,034,800</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,219,858</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,226,311</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,320,096**
Identifying Project and Provider Information:
Title: 1.1.1 Expand Primary Care Capacity – Val Verde County and Del Rio, Texas
Unique RHP ID#: 119877204.1.1 – PASS 1
Performing Provider: Val Verde Regional Medical Center
Performing Provider TPI: 119877204

Project Summary:

Provider Description: Val Verde Regional Medical Center is a 93-bed acute care county hospital located in the medically underserved border community of Del Rio, Texas. It is the only hospital serving Val Verde County. The county’s population is approximately 50,000 with the majority of those persons living in and around Del Rio.

Intervention(s): This project aims to expand primary care resources in this medically underserved community. The hospital has a clinic affiliated with it, and the scope of the project will be to add providers in an effort to expand access to care in Val Verde County.

Need for the project: A community needs assessment was performed, and the top priority identified was to bring more doctors to the community. There is a shortage of primary care physicians in both Del Rio and Val Verde County. The following actuarial data provided by HCAPS Community Needs Assessment Group earlier this year illustrates the gaps in current supply of primary care providers in the clinic’s PSA/SSA versus what is needed to take care of the population:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Current Supply</th>
<th>Physician Demand</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>8</td>
<td>18.91</td>
<td>10.91</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>6</td>
<td>11.05</td>
<td>5.05</td>
</tr>
</tbody>
</table>

Target population: Additional care providers will benefit potentially all of the 48,643 residents of Val Verde County who require care by a doctor. Specifically, there will be an effort to target the sicker patients, the 4,202 that were discharged from an inpatient facility in the previous year, to make sure they have appropriate outpatient care. There will also be an effort toward preventative care under the premise that if there are more providers and more appointment slots, there is a higher probability that patients will seek care more routinely.

Approximately 32% of the population that we serve is uninsured. Our current payer mix for VVRMC consists of 28% Medicaid, 41% Medicare, 20% HMO/PPO and 11% Self Pay. Considering these percentages, the percent of Medicaid/indigent patients we anticipate to serve at the primary care clinics could easily range between 20-30%.

Category 1 or 2 expected patient benefits: The primary benefit will be access to primary care as measured by the increases in clinic visits. In DY 3 we will recruit an additional primary care provider. We estimate our baseline of patient visits will increase from 4,740 visits currently to 7,145 visits by the end of DY 3, with addition of this new provider. In DYs 4 and 5 we have set goals to increase patient visits from this new baseline by 10% and 20%, respectively.

For both primary care physicians, we expect an average of 3 visits per patient per year. The mid-
One key patient benefit of increasing access to and utilization of primary care services will be a decreased dependence on emergency room care by patients who are currently without primary care providers. There will be an effort to track this utilization as well with this patient population.

**Category 3 outcomes:** The measured category 3 outcome associated with this program is patient satisfaction. Currently, the clinic has no formal mechanism to measure patient experience in the clinic as it does for ER and inpatient services. The plan is to develop a similar, formal format to ensure that patients are pleased with the services and value the experience in an effort to enhance the full continuum of care at the hospital and its clinic. The clinic intends to benchmark its results against similar operations and set goals in the top quartile of performers, which is a mark consistent with expectations for other hospital/clinic services. There will be a phased approach to demonstrate progress toward this goal.

**Project Description:**

Establish additional primary care providers to a medically underserved area along the Rio Grande border. The intent is to add primary care providers throughout the life of the project.

The primary goal of this project is to expand primary care in Val Verde County and improve access to services so that there are more clinics available to patients and the number of patients utilizing primary care increases over time. We intend to expand preventative medicine and create an environment that residents of Val Verde County feel like they always can see the doctor, whether that is by appointment, walk-in or through an after-hours offering.

This project will meet the following regional goals:

- The project will encourage working together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered, in the most effective ways
- The project will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
- The project will further develop and maintain a coordinated care delivery system. Finally the project will improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents through increasing primary care capacity. The project will increase capacity by expanding the number of primary care clinics. The project develops and maintains a coordinated care delivery system through the establishment of a nurse advice line. The project improves outcomes while containing cost growth by providing access to primary care providers. Patients who now rely on the emergency room for primary care will then have access to a less costly and more appropriate mode of care.

The challenge and key issue which this project will address will be to reduce the dependency on the emergency room for primary care-type visits due to a lack of access to doctors.

We will also look to develop a call-a-nurse program that will also serve as an additional clinic resource while the patient is at home. This service can aid the patient in decision-making in regards to what healthcare resources are best to utilize given each unique situation. The
community develops more confidence in knowing that health information from a qualified professional is readily available not only in person but over the phone as well.

The 5-year expected outcome is better health, better patient satisfaction, increased utilization of primary care services and a reduced utilization of the ER for this patient population.

This project that we have selected is especially important in RHP 6 as so much of the RHP is rural. In the rural healthcare setting, especially Texas and especially along the border, there is a short supply of healthcare resources. Del Rio and Val Verde County will be better served and healthier if there is more access to physicians.

**Starting Point/Baseline:**

Dr. Charles Rigney (Family Practice) 4,740 visits

We estimate our baseline of patient visits will increase from 4,740 visits currently to 7,145 visits by the end of DY 3, with addition of this new provider.

**Rationale:**

As evidenced in the RHP Community Needs Assessment, access to (or lack of) primary care is a serious issue in Texas, especially in rural parts of Texas. The following Community Needs are specifically related to this project and were identified locally in Del Rio as well:

CN.1 Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

CN.2 A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.

CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

The project option (1.1.1) will be to establish more primary care clinics. Val Verde Regional Medical Center began to seriously tackle this issue in 2011. The hospital established a 501(a) for which it is the sole member for, and as a result developed a recruitment vehicle for physicians and mid-levels. Prior to this organization being established it was even more challenging than it is today to recruit doctors and physician extenders to a rural, border community. Through this effort, primary care clinics have recently been established, and the hospital has good baseline data from which to compare its progress to in improving and increasing access to care to patients in its community. The hospital has just gotten started recruiting providers to the area. It is the intention over the life of this project to attract additional doctors, physician assistants and nurse practitioners to the clinics so that number of clinics can be expanded as well as the number of patients seen in the clinics.

By increasing access, there is a greater opportunity to practice preventative medicine and also watch as utilization of the emergency room declines for these patients declines as well as their
readmission rate to the hospital.

**Process Milestone:**
P-1. Milestone: Establish additional/expand existing/relocate primary care clinics
P-1.1. Metric: Number of additional clinics or expanded hours or space
   a. Documentation of detailed expansion plans
   b. Data Source: New primary care schedule or other Performing Provider
document or other plans as designated by Performing Provider.
   c. Rationale/Evidence: It is well known the national supply of primary care
does not meet the demand for primary care services. Moreover, it is a
goal of health care improvement to provide more preventive and
primary care in order to keep individuals and families healthy and
therefore avoid more costly ER and inpatient care. RHPs are in real
need of expanding primary care capacity in order to be able to
implement the kind of delivery system reforms needed to provide the
right care at the right time in the right setting for all patients.

**Process Milestone:**
P-7. Milestone: Establish a nurse advice line and/or primary care patient appointment unit.
P-7.1. Metric: Documentation of nurse advice line and/or primary care patient appointment unit.
   a. Data Source: Documentation of advice line and appointment unit
      implementation, operating hours and triage policies. Advise line system
      logs, triage algorithms and appointment unit operations/policies.
   b. Rationale: In many cases patients are unaware of the appropriate
      location and timing to seek care for urgent and chronic conditions.
      Implementation of a nurse advice line allows for primary care to be the
      first point of contact and offer clinical guidance around how to mitigate
      symptoms, enhance patient knowledge about certain conditions and
      seek timely care services.

**Process Milestone**
P-5 Train/hire additional primary care providers and staff and/or increase the number of primary
care clinics for existing providers
Metric 1: 5.1 Documentation of increased number of providers and staff and/or clinic sites
Data Source: Documentation of completion of all items described by the RHP plan for this
measure. Hospital or other Performing Provider report, policy, contract or other documentation
Rationale: Additional staff members and providers may necessary to increase capacity to deliver
care.

**Improvement Milestones:**
I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access
for patients seeking services.
I-12.1. Metric: Documentation of increased number of visits. Demonstrate
improvement over prior reporting period.
a. Total number of visits for reporting period
b. Data Source: Registry, EHR, claims or other Performing Provider source
c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

I-14. Milestone: Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period.
I-14.1 Metric: Number of patient served by the nurse advice line. Demonstrate improvement over baseline rates.
a. Numerator: number of unique records created from calls received to the nurse advice line.
b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered)
c. Data Source: Automated data from call center
d. Rationale/Evidence: This measure will indicate how many calls are addressed successfully as well as an overall call abandonment rate. Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person. It is related to the management of emergency calls. This metric speaks to the capacity of the nurse advice line.

One of the key quality improvement efforts will be with all new patients established with new providers will be to track and measure physician and hospital utilization before and after access and interaction with the clinic. The goal will be to increase the clinic intervention with providers as necessary over a historic time period and also over time realize a decreased utilization on hospital inpatient services.

There are no initiatives related to this project that have related activities that are funded by the U.S. department of Health and Human Services.

**Related Category 3 Outcome Measure(s):**

The category 3 Outcome Measure related to this project is Patient Satisfaction (stand alone). As we visited with constituents in the Del Rio and Val Verde County communities, there is a sense of frustration in regards to not being able to get in to see a doctor. Then there is extreme dissatisfaction if the only resource available to them is the emergency room. And no matter how well the hospital is performing in regards to ED throughput, care takes longer and costs more. There is clearly a perception in Del Rio to that Del Rio needs more doctors. Actuarial data supports this claim that Del Rio and Val Verde County are medically underserved.

If the hospital is successful in establishing more clinics and having more providers available, and if the hospital can enhance the patient experience while at the clinics, the hypothesis is that patients will be satisfied with healthcare in their community.

In regards to low-income populations, this group stands to benefit the most from this initiative as this patient population is likely the most dissatisfied with their healthcare in the community. Lack of access typically means a greater dependency on the ER for primary care needs.
The clinic(s) will measure patient satisfaction and will establish Process Milestones in DY 2 & 3:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
P-2 Establish baseline rates – DY 3

For DY 4 & 5, the clinic will have improvement targets (stand-alone measure) as follows:

**OD-6 Patient Satisfaction**

**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

1. are getting timely care, appointments, and information; *(Standalone measure)*

   **a Numerator:** Percent improvement in targeted patient satisfaction domain

   **b Data Source:** Patient survey

   **c Denominator:** Number of patients who were administered the survey

   **d Rationale/Evidence:** The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients’ perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Relationship to other Projects:**

This project is related to 1.2 Increase Training of Primary Care Workforce. To the extent that there are providers within the RHP as well as outside the RHP are focused on this initiative, it helps to increase the pool of providers that are available to expand primary care in medically underserved areas.

This project is also related to 2.4 Redesign to Improve Patient Experience. The Category 3 measure associated with this project is Patient Satisfaction. Our redesign of not only the infrastructure to increase medical resources but also the redesign of how the care is delivered within this newly expanded infrastructure will drive results so that patients are happier with their care and have a greater confidence in the local rural healthcare delivery system.

This project is related to Category 4 measures RD-1 Potentially Preventable Admissions and RD-2 30-day Readmissions. If access to primary care is increased, then the goal will be to see lower utilization of hospital resources as measured by Category 4 measures.

This project is also related to the hospital’s other project, 1.9 Expand Specialty Care Capacity. To the extent that providers are located in the same clinic, and expansion of both primary care
and specialty physicians working together will enhance the communication process and afford the opportunity for patients to move seamlessly through the system. In a small rural community it makes sense to align providers and develop an infrastructure by which everyone is working on the same EMR so that medical information can be shared and to some extent minimize duplication of services.

**Relationship to Other Performing Providers’ Projects in the RHP:**

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<thead>
<tr>
<th>Hospital/Center</th>
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<tbody>
<tr>
<td>University Hospital</td>
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<tr>
<td>Baptist Medical Center</td>
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<tr>
<td>Children’s Hospital of San Antonio</td>
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<tr>
<td>CHRISTUS Santa Rosa</td>
</tr>
<tr>
<td>Frio Regional Hospital (rural performing provider)</td>
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<tr>
<td>Guadalupe Regional Medical Center (rural performing provider)</td>
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<tr>
<td>Peterson Regional Medical Center (rural performing provider)</td>
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<tr>
<td>Medina Regional Hospital (rural performing provider)</td>
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</table>

**Plan for Learning Collaborative:**

Val Verde Regional Medical Center plans for participating in a RHP-wide learning collaborative with other providers, especially in the rural communities, who are also working to expand primary care in medically underserved areas of the state of Texas.

It is our opinion that getting groups together will foster collaboration and sharing of ideas to best come up with plans to accomplish our goals.

RHP6 anchor University Health System intends to do the following, which Val Verde Regional Medical Center will participate in:

- Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
  - Identify participants
  - Establish Learning Collaborative goals
  - Develop a calendar of regular meetings, site visits, and/or conference calls
  - Develop a plan to communicate ideas, data, and successes across the region and state
  - Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
  - Adopt metrics to measure success

**Project Valuation:**

Our approach to valuing this project was by figuring how significant the impact would be to the patient population this clinic and the providers it serves is. Since the majority of the adult population requires some level of medical intervention at least annually, the potential impact is rather significant. If there are more providers to be able to meet the demand, then the overall health of Del Rio and Val Verde county ought to improve. Costs ought to go down. If our hypothesis holds true that by virtue of increasing access to primary care that ER utilization for
level 4 & 5 visits decreases, all other things equal, we will have moved the care delivery system from a more expensive environment to a less expensive environment.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**
P-1 Establish additional/expand existing/relocate primary care clinics  
**Metric 1:** P-1.1 Number of additional clinics or expanded hours or space  
Baseline: 4,740 visits (2012)  
Goal: Develop a strategic plan and process for expanding primary care clinic offerings through the clinic  
Data Source: Evidence of strategic plan  
Milestone 1 Estimated Incentive Payment: $1,021,045

**Milestone 2**
P-7 Establish a nurse advice line and/or primary care patient appointment unit.  
**Metric 1:** P-7.1 Documentation of nurse advice line and/or primary care patient appointment unit  
Baseline: 0, advice line does not exist currently  
Goal: Development of fully functional advice line  
Data Source: internal call logs/tracking system  
Milestone 2 Estimated Incentive Payment: $556,953

**Milestone 3**
P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
**Metric 1:** 5.1 Documentation of  
Milestone 3 Estimated Incentive Payment: $558,572

**Milestone 4**
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1:** I-3.1 Documentation of increased number of visits; demonstrate improvement over prior reporting period  
Baseline: 7,145 patient visits (estimated DY 3 baseline after completion of P-5)  
Goal: 10% increase over DY 3 baseline  
Data Source: EMR, appointment schedule  
Milestone 4 Estimated Incentive Payment: $558,572

**Milestone 5**
I-14 Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit.  
Milestone 5 Estimated Incentive Payment: $461,429

**Milestone 6**
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 4:** I-3.1 Documentation of increased number of visits; demonstrate improvement over prior reporting period  
Baseline: 7,145 patient visits (estimated DY 3 baseline)  
Goal: 20% increase over DY 3 baseline  
Data Source: EMR, appointment schedule  
Milestone 6 Estimated Incentive Payment: $461,429

**Milestone 7**
I-14 Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over
<table>
<thead>
<tr>
<th>Increased number of providers and staff and/or clinic sites</th>
<th>Demonstrate improvement over prior reporting period. Metric 1: 14.1 Number of patient served by the nurse advice line. Demonstrate improvement over baseline rates. Numerator: number of unique records created from calls received to the nurse advice line. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered) Baseline: TBD in DY 3 Goal: 10% increase over DY 4 baseline Data Source: Automated data from call center</th>
<th>Prior reporting period. Metric 1: 14.1 Number of patient served by the nurse advice line. Demonstrate improvement over baseline rates. Numerator: number of unique records created from calls received to the nurse advice line. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered) Baseline: TBD in DY 3 Goal: 20% increase over DY 3 baseline Data Source: Automated data from call center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 1 family practitioner, 1 mid-level provider Goal: recruit at least 1 additional primary care provider Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation</td>
<td>Milestone 3 Estimated Incentive Payment: $556,953</td>
<td>Milestone 5 Estimated Incentive Payment: $558,572</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $556,953</td>
<td>Milestone 5 Estimated Incentive Payment: $558,572</td>
<td>Milestone 7 Estimated Incentive Payment: $461,429</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $1,021,045</th>
<th>Year 3 Estimated Milestone Bundle Amount: $1,113,906</th>
<th>Year 4 Estimated Milestone Bundle Amount: $1,117,144</th>
<th>Year 5 Estimated Milestone Bundle Amount: $922,858</th>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,174,952</strong></td>
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</tbody>
</table>
Identifying Project and Provider Information:

Title: 1.9.2 Expand Specialty Care Capacity – For Val Verde County and Del Rio, Texas
Unique RHP ID#: 119877204.1.2 – PASS 1
Performing Provider: Val Verde Regional Medical Center
Performing Provider TPI: 119877204

Project Summary:

Provider Description: Val Verde Regional Medical Center is a 93-bed acute care county hospital located in the medically underserved border community of Del Rio, Texas. It is the only hospital serving Val Verde County. The county’s population is approximately 50,000 with the majority of those persons living in and around Del Rio.

Intervention(s): This project aims to expand specialty care resources in this medically underserved community. The hospital has a clinic affiliated with it, and the scope of the project will be to add providers in an effort to expand access to care in Val Verde County.

Need for the project: A community needs assessment was performed, and the top priority identified was to bring more doctors to the community. There is a shortage of specialty care physicians in both Del Rio and Val Verde County. The following actuarial data provided by HCAPS Community Needs Assessment Group earlier this year illustrates the gaps in current supply of primary care providers in the clinic’s PSA/SSA versus what is needed to take care of the population:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Current Supply</th>
<th>Physician Demand</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>0</td>
<td>1.39</td>
<td>1.39</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>2.13</td>
<td>1.13</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>0</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.2</td>
<td>3.67</td>
<td>3.47</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>0</td>
<td>1.69</td>
<td>1.69</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>2</td>
<td>3.23</td>
<td>1.23</td>
</tr>
<tr>
<td>Surgery</td>
<td>2</td>
<td>4.26</td>
<td>2.26</td>
</tr>
</tbody>
</table>

Target population: Additional care providers will benefit potentially all of the 48,643 residents of Val Verde County who require care by a doctor. Specifically, there will be an effort to target the sicker patients, the 4,202 that were discharged from an inpatient facility in the previous year, to make sure they have appropriate outpatient care. Because there is a lack of specialists in this medically underserved part of the state, many patients end up traveling to San Antonio for care, which increases the cost of care. However, for many of the socioeconomically challenged patients in the county who cannot afford the trip to San Antonio, they end up not getting the care they need. Ultimately, they end up in the emergency room where their condition is more acute and the cost of care to provide for them, which often includes a transfer to higher level of care, is
significantly more expensive.

Approximately 32% of the population that we serve is uninsured. Our current payer mix for VVRMC consists of 28% Medicaid, 41% Medicare, 20% HMO/PPO and 11% Self Pay. Considering these percentages, the percent of Medicaid/indigent patients we anticipate to serve at the specialty care clinics could easily range between 20-30%.

**Category 1 or 2 expected patient benefits:** The primary benefit will be access to specialty care as measured by the increase in encounters in the clinic. Currently we are actively trying to recruit a cardiologist; a mid-level specializing in cardiology, an ENT and a urologist. Recruitment into these and other specialties will likely be completed during DY 3. Based on the small number of specialty care clinic visits currently (1,100 in 2012) combined with recruitment into cardiology ENT and urology, we anticipate 2,700 specialty clinic visits by the end of DY 3. In DYs 4 and 5 we have set goals to increase patient visits from this new baseline by 10% and 20%, respectively.

For all specialist providers we expect an average of 2 visits per patient per year.

One key patient benefit of increasing access to and utilization of specialty care services will be a decrease in patient transfers. Access to specialty care is extremely limited. It causes many patients to be transferred 2 ½ hours to San Antonio for care. Driving to visit specialty providers in San Antonio becomes very expensive for residents of our community over time. Reducing the need for this travel through greater access to local providers is a significant benefit to our population.

There will be an effort to track this utilization as well with this patient population.

**Category 3 outcomes:** The measured category 3 outcome associated with this program is patient satisfaction. Currently, the clinic has no formal mechanism to measure patient experience in the clinic as it does for ER and inpatient services. The plan is to develop a similar, formal format to ensure that patients are pleased with the services and value the experience in an effort to enhance the full continuum of care at the hospital and its clinic. The clinic intends to benchmark its results against similar operations and set goals in the top quartile of performers, which is a mark consistent with expectations for other hospital/clinic services. There will be a phased in approach to demonstrate progress toward this goal.

**Project Description:**

Establish additional specialty care providers to a medically underserved area along the Rio Grande border. The intent is to add specialty care providers throughout the life of the project.

The primary goal of this project is to expand specialty care in Val Verde County and improve access to services. The hospital intends to make services available locally that are currently not available at all or limited services at best.

This project will meet the following regional goals:

- The project will encourage working together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered, in the most effective ways
- The project will improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
The project will further develop and maintain a coordinated care delivery system. Finally the project will improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents through increasing specialty care capacity. The project will increase capacity by expanding the number of specialty clinics. The project develops and maintains a coordinated care delivery system through implementing “raise the floor” quality improvement initiatives agreed upon during semi-annual RHP learning collaboratives. The project improves outcomes while containing cost growth through reducing transfers into San Antonio and by focusing on improving patient satisfaction.

The challenge and key issue which this project will address will be to see to it that residents do not have to travel to large, urban areas for specialty care. There are many people in Val Verde County that cannot afford the trip to San Antonio and thus go without seeing a specialist until their condition worsens. At this point they access the ER and often times must be acutely transferred by air ambulance.

The 5-year expected outcome is better health, better patient satisfaction, increased utilization of specialty care services and appropriate utilization of the ER for this patient population.

This project that we have selected is especially important in RHP 6 as so much of the RHP is rural. In the rural healthcare setting, especially Texas and especially along the border, there is a short supply of healthcare resources. Del Rio and Val Verde County will be better served and healthier if there is more access to physicians.

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
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<tbody>
<tr>
<td>2012</td>
</tr>
<tr>
<td>Urology-800 visits</td>
</tr>
<tr>
<td>Vascular Surgery-300 visits</td>
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</tbody>
</table>

Based on the small number of specialty care clinic visits currently (1,100 in 2012) combined with recruitment into cardiology ENT and urology, we anticipate 2,700 specialty clinic visits by the end of DY 3. We will use this as our baseline in DY 4 and 5.

<table>
<thead>
<tr>
<th>Rationale:</th>
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<tr>
<td>As evidenced in the RHP Community Needs Assessment, access to (or lack of) specialty care is a serious issue in Texas, especially in rural parts of Texas. The following Community Needs are specifically related to this project and were identified locally in Del Rio as well:</td>
</tr>
</tbody>
</table>

- **CN.1** Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- **CN.2** A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.
- **CN.3** Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

The project option (1.9.2) will be to improve access to specialty care. Val Verde Regional Medical Center
Val Verde Regional Medical Center began to seriously tackle this issue in 2011. The hospital established a 501(a) for which it is the sole member for, and as a result developed a recruitment vehicle for physicians and mid-levels. Prior to this organization being established it was even more challenging than it is today to recruit doctors and physician extenders to a rural, border community. Through this effort, specialists are currently being recruited to practice in Del Rio. It will be reasonable to track progress as additional providers are added and clinics established. It is the intention over the life of this project to attract additional doctors, physician assistants and nurse practitioners to the clinics so that number of clinics can be expanded as well as the number of patients seen in the clinics. By increasing access, there is a greater opportunity to serve these patients timely and locally.

Project Components:

Through “Improving Rural Access to Specialty Care”, we propose to meet all required project components, except for component B.

E. Identify high impact/most impacted specialty services and gaps in care and coordination. This component will be accomplished in DY 2. We plan to hire a third-party healthcare consultant to perform this specialty care gap assessment. The results of this assessment will establish a firm baseline for our project in those specialty care areas where there are gaps in coverage. Our current specialty clinic visit volume (2012) is 1,100 visits with 800 urology visits and 300 vascular surgery visits.

F. Increase the number of residents/trainees choosing targeted shortage specialties. This project component will not be addressed in this project. The reason this component is left out is because of the small size of the hospital (93 licensed beds) and its rural location (150+ miles west of San Antonio). Currently our facility does not have the resources, space or staff to provide residencies for physicians. Also, completing this project component is unrealistic given the few specialists available in our area to provide such training.

G. Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention). Our community is an underserved market considering the lack of specialty care services and its designation as a HPSA. We plan to meet this project component through increasing the number of specialist providers, clinic hours and/or procedure hours in targeted specialties. This will occur in DY 3.

H. Conduct quality improvement for project using methods such as rapid cycle improvement. We plan to meet this project component through participating in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP. These meetings will be to promote collaborative learning around shared or similar projects. We will then implement at least one “raise the floor” improvement initiatives established at the semiannual meeting per year for DY 3, 4 and 5.

Process Milestone:
P-1 Milestone: Conduct specialty care gap assessment based on community need
P-1.1 Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).
   a. Data Source: Needs Assessment
   b. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up
supplies of specialists to meet demand for services and improve specialty care access

**Process Milestone:**
P-11. Milestone: Launch/expand a specialty care clinic (e.g., pain management clinic)
P-11.1. Metric: Establish/expand specialty care clinics
   a. Number of patients served by specialty care clinic
   b. Data Source: Documentation of new/expanded specialty care clinic
   c. Rationale/Evidence: Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care.
   Additionally, specialty care clinics allow for enhanced care coordination for those patients requiring intensive specialty services.

**Process Milestone**
P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1: 21.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP
   a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes
   Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers

**Metric 2:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting
   a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implement the initiative after the meeting
   Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers

**Improvement Milestone:**
I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).
   a. Total number of visits for reporting period
   b. Data Source: Registry, EHR, claims or other Performing Provider source
   c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

One of the key quality improvement efforts will be with all new patients established with new providers will be to track and measure physician and hospital utilization before and after access and interaction with the clinic. The goal will be to increase the clinic intervention with providers...
as necessary over a historic time period and also over time realize a decreased utilization on hospital inpatient services.

There are no initiatives related to this project that have related activities that are funded by the U.S. department of Health and Human Services.

**Related Category 3 Outcome Measure(s):**

The category 3 Outcome Measure related to this project is Patient Satisfaction (stand alone). As we visited with constituents in the Del Rio and Val Verde County communities, there is a sense of frustration in regards to not being able to get in to see a specialist. Then there is extreme dissatisfaction if the only resource available to them is the emergency room. And no matter how well the hospital is performing in regards to ED throughput, care takes longer and costs more. There is clearly a perception in Del Rio to that Del Rio needs more doctors. Actuarial data supports this claim that Del Rio and Val Verde County are medically underserved.

If the hospital is successful in establishing more clinics and having more specialists available, and if the hospital can enhance the patient experience while at the clinics, the hypothesis is that patients will be satisfied with healthcare in their community.

In regards to low-income populations, this group stands to benefit the most from this initiative as this patient population is likely the most dissatisfied with their healthcare in the community. Lack of access typically means a greater dependency on the ER for primary care needs.

The clinic(s) will measure patient satisfaction and will establish Process Milestones in DY 2 & 3:

P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
P- 2 Establish baseline rates – DY 3

For DY 4 & 5, the clinic will have improvement targets (stand-alone measure) as follows:

**OD-6 Patient Satisfaction**

**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

1. are getting timely care, appointments, and information; *(Standalone measure)*
   a Numerator: Percent improvement in targeted patient satisfaction domain
   b Data Source: Patient survey
   c Denominator: Number of patients who were administered the survey
   d Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients’ perspectives on hospital care. The surveys are designed to
produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Relationship to other Projects:**

This project is related to 1.7 Introduce, Expand or Enhance Telehealth/Telemedicine. Part of our strategy to gain access to specialists in our rural community will be through telemedicine and robotic technology. It is also related to 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization as if the hospital is successful in developing additional behavioral health services to the community it has the opportunity to impact this project as well.

This project is also related to 2.4 Redesign to Improve Patient Experience. The Category 3 measure associated with this project is Patient Satisfaction. Our redesign of not only the infrastructure to increase medical resources but also the redesign of how the care is delivered within this newly expanded infrastructure will drive results so that patients are happier with their care and have a greater confidence in the local rural healthcare delivery system.

This project is related to Category 4 measures RD-1 Potentially Preventable Admissions and RD-2 30-day Readmissions. If access to primary care is increased, then the goal will be to see lower utilization of hospital resources as measured by Category 4 measures.

This project is also related to the hospital’s other project, 1.1 Expand Primary Care Capacity. To the extent that providers are located in the same clinic, and expansion of both primary care and specialty physicians working together will enhance the communication process and afford the opportunity for patients to move seamlessly through the system. In a small rural community it makes sense to align providers and develop an infrastructure by which everyone is working on the same EMR so that medical information can be shared and to some extent minimize duplication of services.

**Relationship to Other Performing Providers’ Projects in the RHP:**

University Hospital  
Baptist Medical Center  
Children’s Hospital of San Antonio  
Methodist Hospital  
Southwest General Hospital  
Dimmit County Memorial Hospital (rural performing provider)  
Connally Memorial Medical Center (rural performing provider)

**Plan for Learning Collaborative:**
Val Verde Regional Medical Center plans for participating in a RHP-wide learning collaborative with other providers, especially in the rural communities, who are also working to expand primary care in medically underserved areas of the state of Texas.

It is our opinion that getting groups together will foster collaboration and sharing of ideas to best come up with plans to accomplish our goals.

RHP6 anchor University Health System intends to do the following, which Val Verde Regional Medical Center will participate in:

Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
Identify participants
Establish Learning Collaborative goals
Develop a calendar of regular meetings, site visits, and/or conference calls
Develop a plan to communicate ideas, data, and successes across the region and state
Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
Adopt metrics to measure success

**Project Valuation:**

Our approach to valuing this project was by figuring how significant the impact would be to the patient population this clinic and the providers its serves is. Specialty care, especially in areas like cardiology, vascular surgery and podiatry in an area with so much diabetes and hypertension, is very important to the community. In additional, behavioral services are in short supply in Del Rio. When valuing our two projects, we arrived at an equal weight between primary and specialty care. If there are more providers to be able to meet the demand, then the overall health of Del Rio and Val Verde county ought to improve. Costs ought to go down. If our hypothesis holds true that by virtue of increasing access to specialty care that ER utilization and air transfers decrease, all other things equal, we will have moved the care delivery system from a more expensive environment to a less expensive environment.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>119877204.3.2</th>
<th>3.1T-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
</table>

### Milestone 1
P-1 Conduct specialty care gap assessment based on community need
**Metric 1:** P-1.1 Documentation of gap assessment.
**Baseline:** 0
**Goal:** Establish a baseline with gaps in specialty care documented. Identify high impact specialty care services to fill gaps and meet population needs.
**Data Source:** Needs Assessment

**Milestone 1 Estimated Incentive Payment:** $1,021,045

### Milestone 2
P-11 Launch/expand a specialty care clinic
**Metric 1:** P-11.1
Establish/expand specialty care clinics
**Baseline:** 1,100 specialty clinic visits in 2012, (800 urology, 300 vascular surgery).
**Goal:** Expand number of patients served by specialty clinic
**Data Source:** Documentation of new/expanded specialty clinic

**Milestone 2 Estimated Incentive Payment:** $556,953

### Milestone 3
P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around

### Milestone 4
I-23 Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services
**Metric 3:** I-23.1 Documentation of increased number of visits; demonstrate improvement over prior reporting period
**Baseline:** 2,700 visits (estimated DY 3 baseline after accomplishment of P-11)
**Goal:** 10% increase over DY 3 baseline
**Data Source:** EMR, appointment schedule

**Milestone 4 Estimated Incentive Payment:** $558,572

### Milestone 5
I-23 Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services
**Metric 4:** I-23.1 Documentation of increased number of visits; demonstrate improvement over prior reporting period
**Baseline:** Baseline: 2,700 visits (estimated DY 3 baseline after accomplishment of P-11)
**Goal:** 20% increase over DY 3 baseline
**Data Source:** EMR, appointment schedule

**Milestone 5 Estimated Incentive Payment:** $461,429

### Milestone 6
P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and
Metric 1: 21.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP

Baseline: 0

Goal: attend 2 collaborative learning RHP meetings

Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes

Metric 2: Implement the “raise the floor” improvement initiatives established at the semiannual meeting

Baseline: 0

Goal: implement at least 1 “raise the floor” improvement initiative.

Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implement the initiative after the meeting.

Milestone 3 Estimated Incentive Payment: $556,953
<table>
<thead>
<tr>
<th>Milestone 5 Estimated Incentive Payment: $558,572</th>
<th>Milestone 7 Estimated Incentive Payment: $461,429</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,021,045</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,113,906</td>
</tr>
<tr>
<td>Year 4 Estimated Milestone Bundle Amount: $1,117,144</td>
<td>Year 5 Estimated Milestone Bundle Amount: $922,858</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,174,952**
Identifying Project and Provider Information:
Title: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region – Val Verde County and Del Rio, Texas
Unique RHP ID#: 119877204.1.3 – PASS 2
Performing Provider: Val Verde Regional Medical Center (VVRMC)
Performing Provider TPI: 119877204

Project Summary:
Provider Description: Val Verde Regional Medical Center is a 93-bed acute care county hospital located in the medically underserved border community of Del Rio, Texas. It is the only hospital serving Val Verde County. The county’s population is approximately 50,000 with the majority of those persons living in and around Del Rio.

Intervention(s): This project aims to develop a robust telemedicine program aimed at enhancing access to services across the full continuum of care for patients in the hospital and at the clinic.

Need for the project: A community needs assessment was performed, and the top priority identified was to bring more doctors to the community. There are three targeted areas for the telemedicine program to have an impact: 1) behavioral health, 2) neurology and 3) cardiology. The telemedicine services will be primarily offered in the ER and on the inpatient units. Currently, there are no resources available in any of these three important specialties for patients who require these services in the ER or inpatient setting. While there are efforts underway to recruit permanent specialists to Val Verde County (see 119877024.1.2), the likelihood of procuring all specialties permanently to our rural border community is small. However, with this technology, specialists in urban areas can access and provide services to patients remotely while significantly enhancing the delivery of care.

Target population: Additional care providers will benefit potentially all of the 48,643 residents of Val Verde County who require care by a doctor. Specifically, patients who present to the ER or who are admitted to the hospital with diagnosis in neurology (stroke), cardiology (heart attack), and psychiatry (mental health) will be ideal candidates for telemedicine intervention.

Approximately 32% of the population that we serve is uninsured. Our current payer mix for VVRMC consists of 28% Medicaid, 41% Medicare, 20% HMO/PPO and 11% Self Pay. Considering these percentages, the percent of Medicaid/indigent patients we anticipate to serve in the telemedicine program could easily range between 20-30%.

Category 1 or 2 expected patient benefits: In DY 3 we will expand the geriatric psych telemedicine program to additional medical specialties, based upon regional and community need. Our baseline is 420 Gero psych telemedicine visits (2012). However, we have set DY 4, and 5 goals at 1000 and 1150 visits, respectfully. Based on the specialties the telemedicine program expands into and the provider, telemedicine visits per patient may range between 1 and 3 per patient per year.

The primary benefit will be access to specialty care as measured by the increase in visits through telemedicine. This is a new program, and its benefits will be easily measurable. We intend to realize a reduction in both ground and air transfers as a result of the telemedicine program as more patients can be treated locally in Del Rio.
Category 3 outcomes: The measured category 3 outcome associated with this program is patient satisfaction. Our plan is to develop a formal patient satisfaction response geared specifically for patients receiving services through telemedicine. With this new technology it will be important to make sure that patients have the confidence in this non-traditional process and that the results being delivered are positively perceived.

### Project Description:

**Project Description**

VVRMC intends to introduce a robotic telemedicine program for access to specialty care in its rural community in the emergency room and inpatient bedded units.

**Goals**

Goals include expanding access to specialty care and being able to provide specialty care more timely. Many patients present to the VVRMC emergency room today and immediately must be transferred out to a higher level of care. This transfer is oftentimes risky when treatment time is of the essence and is also costly. Through robotic telemedicine, specialists are available to better interact on the case, intervene quicker and potentially reduce or eliminate the need to transfer patients out of the facility.

**Challenges/Issues**

The challenge and key issue will be to align with specialists who have an interest in this technology and a commitment to the rural community. The project will not work unless those specialists on the other end treat episodes of care that present via this medium just as they would in their locality from a priority perspective. Another challenge is developing protocols and techniques that parties on both sides can agree upon.

This will be brand new technology which stands the chance to greatly improve patient care, but some of the local, rural community physicians often times are slow to change, especially when it involves technology.

**5-Year Expected Outcome**

The 5-year expected outcome is better health, better patient satisfaction, increased utilization of specialty care services and reduced transfers out of the facility.

**Relationship to Regional Goals**

This project that we have selected is especially important in RHP 6 as so much of the RHP is rural. In the rural healthcare setting, especially Texas and especially along the border, there is a short supply of healthcare resources. Del Rio and Val Verde County will be better served and healthier if there is more access to physicians.

**Starting Point/Baseline:**

Our baseline is 420 Gero psych telemedicine visits (2012), No baseline exists for other specialties we plan to expand into.
Rationale:

As evidenced in the RHP Community Needs Assessment, access to (or lack of) specialty care is a serious issue in Texas, especially in rural parts of Texas. The following Community Needs are specifically related to this project and were identified locally in Del Rio as well:

CN.1 Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

CN.2 A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.

CN.3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

The project option (1.7.1) will be to implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region. VVRMC has invested in robotic telemedicine technology in the past 3 months with the intent to deploy the resource to expand services to patients presenting with specific conditions in the emergency room and on the inpatient bedded units. The primary service areas where VVRMC sees the greatest benefit as evidenced by the community needs assessment is in cardiology, neurology and behavioral health.

By increasing access, there is a greater opportunity to serve patients of Val Verde County timely and locally.

By virtue of having the technology in place and establishing relationships with medical and surgical specialists who are willing to service our area, we will have accomplished the first core component required. The second core component will be accomplished as the team will continually participate in quality improvement efforts to help evaluate the merits of the program. This includes but is not limited to identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Process Milestone:
P-1. Milestone: Conduct needs assessment to identify needed specialties that can be provided via telemedicine
P-1.1. Metric: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.
a. Submission of completed needs assessment
b. Data Source: Needs assessment
c. Rationale/Evidence: It is important to expand telemedicine to areas where greatest need and highest potential for impact is demonstrated in order to have optimal effect.

P-3. Milestone: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.
P-3.1. Metric: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.

a. Submission of implementation documentation
b. Data Source: Program materials
c. Rationale/Evidence: It is important to expand telemedicine to areas where greatest need and highest potential for impact is demonstrated in order to have optimal effect.

**Improvement Milestone:**

I-12. Milestone: Increase number of telemedicine visits for each specialty identified as high need

I-12.1. Metric: Number of telemedicine visits

a. Numerator: Number of visits in which patients are seen using telemedicine services for each type of medical or surgical subspecialty provided by specified timeframe (e.g. one year) and geographic area in a RHP or for individual provider.
b. Denominator: Number of patients referred to medical specialties
c. Data Source: EHR or electronic referral processing system; encounter records from telemedicine program
d. Rationale: demonstrate increase in access due to teleservices

One of the key quality improvement efforts will be with all new patients established with new providers will be to track and measure physician and hospital utilization before and after access and interaction with the clinic. The goal will be to increase the clinic intervention with providers as necessary over a historic time period and also over time realize a decreased utilization on hospital inpatient services.

There are no initiatives related to this project that have related activities that are funded by the U.S. department of Health and Human Services.

**Related Category 3 Outcome Measure(s):**

The category 3 Outcome Measure related to this project is Patient Satisfaction (stand alone). As we visited with constituents in the Del Rio and Val Verde County communities, there is a sense of frustration in regards to access to specialty care. Because of this frustration, many people in the community avoid the local hospital for fear that the hospital does not have the appropriate resources to take care of their healthcare need. There is clearly a perception in Del Rio to that Del Rio needs more doctors. One alternative to permanent recruitment to this rural community is to access additional doctors through telemedicine. Actuarial data supports this claim that Del Rio and Val Verde County are medically underserved.

If the hospital is successful in establishing better access to specialists through telemedicine, and if the hospital can enhance the patient experience while at the clinics, the hypothesis is that patients will be satisfied with healthcare in their community.

In regards to low-income populations, this group stands to benefit the most from this initiative as
this patient population is likely the most dissatisfied with their healthcare in the community. Lack of access typically means a greater dependency on the ER for specialty care needs which through this project can now be better accessed through telemedicine.

VVRMC will measure patient satisfaction for patients who access care through telemedicine and will establish Process Milestones in DY 2 & 3:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
P-2 Establish baseline rates – DY 3

For DY 4 & 5, the clinic will have improvement targets (stand-alone measure) as follows:

**OD-6 Patient Satisfaction**
**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
(1) are getting timely care, appointments, and information; *(Standalone measure)*

a Numerator: Percent improvement in targeted patient satisfaction domain
b Data Source: Patient survey
c Denominator: Number of patients who were administered the survey
d Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Relationship to other Projects:**
This project is related to 1.9 Expand Specialty Care Capacity. In the 1.9 project, there will be targeted specialists that VVRMC strategically works to recruit permanently to Val Verde County. However, there are certain specialties that logistically do not make sense to have on a full-time basis but these services are needed ad hoc. This certainly is the case in the emergency room and during acute situations while patients are in the hospital. Through robot telemedicine technology, VVRMC will work to expand access to specialists who otherwise would likely never be providing services in a rural community.

This project is also related to 2.4 Redesign to Improve Patient Experience. The Category 3 measure associated with this project is Patient Satisfaction. Our redesign of not only the infrastructure to increase medical resources but also the redesign of how the care is delivered within this newly expanded infrastructure will drive results so that patients are happier with their
care and have a greater confidence in the local rural healthcare delivery system.

This project is related to Category 4 measures RD-1 Potentially Preventable Admissions and RD-2 30-day Readmissions. If access to specialists through telemedicine is increased, then the goal will be to see lower utilization of hospital resources as measured by Category 4 measures ongoing.

<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital</td>
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<tr>
<td>CHRISTUS Santa Rosa</td>
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<tr>
<td>Methodist Hospital</td>
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<tr>
<td>UT Health Science Center</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan for Learning Collaborative:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Val Verde Regional Medical Center plans for participating in a RHP-wide learning collaborative with other providers, especially in the rural communities, who are also working to expand primary care in medically underserved areas of the state of Texas.</td>
</tr>
</tbody>
</table>

It is our opinion that getting groups together will foster collaboration and sharing of ideas to best come up with plans to accomplish our goals.

RHP6 anchor University Health System intends to do the following, which Val Verde Regional Medical Center will participate in:

Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:

Identify participants
Establish Learning Collaborative goals
Develop a calendar of regular meetings, site visits, and/or conference calls
Develop a plan to communicate ideas, data, and successes across the region and state
Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
Adopt metrics to measure success

<table>
<thead>
<tr>
<th>Project Valuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our approach to valuing this project was by figuring how significant the impact would be to the patient population this technology serves. Specialty care, especially in areas like cardiology, neurology and psychiatry via telemedicine is very important to the community. This effort is the only Pass 2 project for VVRMC, and therefore we have assigned the full value of the Pass 2 allocation to this project.</td>
</tr>
</tbody>
</table>
1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region – Val Verde County and Del Rio, Texas

Val Verde Regional Medical Center

TPI - 119877204

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1**
P-1 Milestone: Conduct needs assessment to identify needed specialties that can be provided via telemedicine

**Metric 1:** P-1.1 Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.

**Goal:** Document needs assessment a. Data Source: Needs Assessment

**Milestone 1 Estimated Incentive Payment:** $543,833

**Year 2 Estimated Milestone Bundle Amount:** $543,833

**Milestone 2**
P-3 Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.

**Metric 2:** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.

**Goal:** Develop documentation in time period Data Source: Program materials

**Milestone 2 Estimated Incentive Payment:** $594,202

**Year 3 Estimated Milestone Bundle Amount:** $594,202

**Milestone 3**
I-12 Increase number of telemedicine visits for each specialty identified as high need

**Metric 3:** I-12.1 Number of telemedicine visits

Baseline: 420 Gero psych telemedicine visits (2012)

Goal: 1,000 telemedicine program visits Data Source: EMR, appointment schedule

**Milestone 3 Estimated Incentive Payment:** $598,044

**Year 4 Estimated Milestone Bundle Amount:** $598,044

**Milestone 4**
I-12 Increase number of telemedicine visits for each specialty identified as high need

**Metric 4:** I-12.1 Number of telemedicine visits

Baseline: 420 Gero psych telemedicine visits (2012)

Goal: 1,150 telemedicine program visits Data Source: EMR, appointment schedule

**Milestone 4 Estimated Incentive Payment:** $493,436

**Year 5 Estimated Milestone Bundle Amount:** $493,436

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,229,516
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>1.2.2 Increase the number of primary care providers (nurse practitioners and physician assistants) and other clinicians/staff (allied health professionals)</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>092414401.1.1 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Community Medicine Associates</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>092414401</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider:** Community Medicine Associates (CMA) is the provider group practice of University Health System, a publicly supported, academic medical center and safety net provider. CMA serves the San Antonio area with an estimated population of 2 million. CMA currently has approximately 100 providers who practice within an ambulatory network of 19-primary, specialty and preventive health clinics located throughout Bexar County.

**Intervention(s):** Community Medicine Associates will increase the number of mid-level provider and allied health professional trainees, including Nurse Practitioners and Physician Assistants, in the primary care setting by increasing the number of training slots available to mid-level provider and allied health professional students.

**Need for the project:** Texas ranks last among the six most-populous states in both the ratio of active patient care physicians per capita and the ratio of active primary care physicians in patient care per capita. In comparison to all 50 states, Texas ranks near the bottom of the list: 46th for ratio of active patient care physicians per capita and 48th for active patient care primary care physicians per capita *(Source: 2011 State Physician Workforce Data Book, Assoc. of American Medical Colleges).* Nurse Practitioners and Physician Assistants can serve as an extension to the primary care physician.

**Target population:** The target population will include the CMA patient population which is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay.

**Category 1 or 2 expected patient benefits:** The Health System will increase mid-level provider training programs in DY2 through DY5. While students are in this program, they will be trained in the PCMH model and disease registry use, will focus on population health, and assist providers in managing their panels. Practice and focus in these areas will improve patient experience and outcomes.

- **DY2**- Increase the number of mid-level trainees by 2 over baseline; 17 trainees for year.
- **DY3**- Increase the number of mid-level trainees by 4 over baseline; 19 trainees for year.
- **DY4**- Increase the number of mid-level trainees by 6 over baseline; 21 trainees for year.
- **DY5**- Increase the number of mid-level trainees by 8 over baseline; 23 trainees for year.

**Category 3 outcomes:**

- **DY4** – Decrease ED visits by TBD% for patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma from baseline.
- **DY5** – Decrease ED visits by TBD% for patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma from baseline.
diagnoses, diabetes exacerbations, and asthma from baseline

**Project Description:**

Our aim is to increase training of allied health providers including Nurse Practitioners and Physician assistants in the primary care setting. Our goal is to expand the primary care workforce to address the challenges of access to care and train provider and care team member students in patient centered concepts.

**Starting Point/Baseline:**

As of University Health System Year end September 30, 2012 CMA primary care Nurse Practitioners and Physician Assistants trained by this program is 15.

**Rationale:**

Passage of the Affordable Care Act (ACA) and the success in expanding high quality affordable care to millions of Americans will be determined, in large part, by the strength and capacity of the primary care workforce. National studies on access to health care make salient the importance of investing in a primary care workforce that will meet the health needs of an aging population as well as rapidly growing minority populations. Demographic and market forces are also having an impact on the current primary care workforce both in terms of retirement as well as the declining number of medical students choosing primary care as their career focus. In addition, primary care providers are geographically mal-distributed; often located in major urban centers and less likely to work in rural, economically underserved areas with high minority populations. This growing shortage has subsequently led to increased wait times, lower quality of care and poor patient experience.

Texas has consistently remained one of the top states in the nation in population growth fueled largely by a migration from other states as well as a large Hispanic immigrant population. However, Texas ranks last among the six most-populous states in both the ratio of active patient care physicians per capita and the ratio of active primary care physicians in patient care per capita. In comparison to all 50 states, Texas ranks near the bottom of the list: 46th for ratio of active patient care physicians per capita and 48th for active patient care primary care physicians per capita (Source: 2011 State Physician Workforce Data Book, Assoc. of American Medical Colleges). Increasing the supply of primary care doctors has become a focus through health care reform.

This project specifically addresses community need identification number three (CN3) which finds that large segments of the population in RHP 6 lack access to medical and dental care as result of high percentage of the population being uninsured and a limited supply of health care provider in close proximity to patients in need.

This project directly responds to this community need by expanding allied health professional training. This program is central to addressing the primary care workforce shortage. University Health System has served as a primary care training site for the University of Texas Health Science Center at San Antonio (UTHSCSA) school of Allied Health and seeks to expand primary care training opportunities. In addition, by working with our CareLink members directly, we will provide much needed access to primary care while training mid-level providers. The CareLink program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private...
funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health.

By increasing the number of allied health provider training slots, the project addresses the national primary care workforce shortage. Students in this program will have the added benefit of being trained and participating in the Patient Centered Medical Home model and disease registries. Students in this program will also develop a focus on population health by assisting providers in the management of their panels during their training, which will improve the health outcomes in the community.

### Related Category 3 Outcome Measure(s):

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The targeted population will be the Carelink members assigned to University Health System patient centered medical homes.

**IT-9.2 ED appropriate utilization (Standalone measure)**

- Reduce all ED visits (including ACSC)271
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

### Relationship to Other Projects:

**This Project is related to:**

92414401.2.2 Enhance/Expand Medical Homes – The PCMH is designed to increase access to primary care through the presence of a medical home model, and access to specialty and preventive services offered in one location, in close proximity to patient homes and communities.

92414401.2.1 Apply evidence-based care management model to patients identified as having high-risk care needs: Implement Care Model for University Health System Clinic settings.

**Relationship to Other Performing Providers’ Projects in the RHP:**

**This Project is related to:**

136141205.1.2 Expand primary care capacity. Training future providers in primary will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites.
136141205.1.4 Introduce, Expand, or Enhance Telemedicine/Tele-health
Telemedicine can be utilized to expand services and access to new clinical sites and will serve to
teach new providers this new modality in treating patients.

136141205.2.4 Establish/Expand a Patient Care Navigation Program. This project will link much
needed care coordination, social support and culturally competent care to vulnerable patient
populations at risk for admissions and re-admissions.

136141205.2.5 Use of Palliative Care Programs: Patients in the medical homes with chronic end
of life conditions will have an avenue that addresses patient populations who are at risk for
suffering, frequent emergency room visits, admissions and death.

Plan for Learning Collaborative:
This project lends itself to participation in learning collaboratives as other Performing Providers
in RHP6 seek to expand the primary care workforce services in other parts of the region for
similar patient populations. Processes and techniques developed and implemented during this
project will be documented by the project team. Successes as well as lessons learned will be
shared with regional collaborators who are also working to improve primary care access.

Project Valuation:
The project achieves the waiver goal and meets community needs by expanding primary care in
a predominantly Hispanic, underserved area of Bexar County. This program builds the primary
care workforce, strengthens healthcare linkages with local community partners and enhances
access to health care services to a target population who struggle with poverty, receive acute or
emergency healthcare services only, and do not have usual providers. In addition, many in the
target population have chronic disease; with no primary care access these condition will become
far more complicated and costly to treat. Access to a primary care medical home been has shown
to improve health, improve health care, and lower care costs.
<table>
<thead>
<tr>
<th>092414401.1.1 PASS 2</th>
<th>1.2.2</th>
<th>N/A</th>
<th>1.2.2 Increase the number of primary care providers (nurse practitioners and physician assistants) and other clinicians/staff (allied health professionals)</th>
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<tbody>
<tr>
<td>Community Medicine Associates</td>
<td>TPI - 092414401</td>
<td></td>
<td></td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>092414401.3.1</td>
<td>3.IT-9.2</td>
<td>ED appropriate utilization (Standalone measure)</td>
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<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1**
P-2: Expand primary care training physician assistants and nurse practitioners.
Metric 1 P2.1 Expand the mid-level provider and physician assistant training programs and/or rotations.
Goal: Secure letter of intent or memo of understanding from training program as evidence of agreement to expand program
Data Source: documentation of applications and agreements to expand training programs

**Milestone 2**
I-11: Increase primary care training or rotations

**Milestone 3**
P-3: Expand positive primary care exposure for trainees
Metric 1 [P-3.2]: Train trainees in medical home model, chronic care model and/or disease registry use; have primary care trainees participate in medical homes by managing panels
Goal: 50% of eligible trainees will be trained in PCMH model
Data Source: documentation of program. Rotation hours

**Milestone 4**
I-11: Increase primary care training or rotations
Metric 1 [I-11.4]: Increase the number of primary care trainees by absolute number
Baseline: 15 ML students trained at year end September 30, 2012
Goal: 6 new ML and allied health trainees over baseline
Data Source: Training schedules

**Milestone 5**
I-11: Increase primary care training or rotations
Metric 1 [I-11.4]: Increase the number of primary care trainees by absolute number
Baseline: 15 ML students trained at year end September 30, 2012
Goal: 6 new ML and allied health trainees over baseline
Data Source: Training schedules

**Milestone 6**
P-3: Expand positive primary care exposure for trainees
Metric 1 [P-3.2]: Train trainees in medical home model, chronic care model and/or disease registry use; have

**Milestone 7**
I-11: Increase primary care training or rotations
Metric 1 [I-11.4]: Increase the number of primary care trainees by absolute number
Baseline: 15 ML students trained at year end September 30, 2012
Goal: 8 new ML and allied health trainees over baseline
Data Source: Training schedules

**Milestone 8**
P-3: Expand positive primary care exposure for trainees
Metric 1 [P-3.2]: Train trainees in medical home model, chronic care model and/or disease registry use; have
<table>
<thead>
<tr>
<th>Metric 1 [I-11.4]: Increase the number of primary care trainees by absolute number</th>
<th>number of primary care trainees by absolute number</th>
<th>primary care trainees participate in medical homes by managing panels</th>
<th>primary care trainees participate in medical homes by managing panels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 15 ML students trained at year end September 30, 2012</td>
<td>Goal: 2 new ML and allied health trainees over baseline</td>
<td>Goal: 75% of eligible trainees will be trained in PCMH model</td>
<td>Goal: 100% of eligible trainees will be trained in PCMH model</td>
</tr>
<tr>
<td>Data Source: Training schedules</td>
<td>Data Source: Training schedules</td>
<td>Data Source: documentation of program. Rotation hours</td>
<td>Data Source: documentation of program. Rotation hours</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $908,312.50</td>
<td>Milestone 4 Estimated Incentive Payment: $949,020.50</td>
<td>Milestone 6 Estimated Incentive Payment: $962,231</td>
<td>Milestone 8 Estimated Incentive Payment: $983,184</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $1,816,625 | Year 3 Estimated Milestone Bundle Amount: $1,898,041 | Year 4 Estimated Milestone Bundle Amount: $1,924,462 | Year 5 Estimated Milestone Bundle Amount: $1,966,368 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,605,496**
Title: 1.10.1 Enhance improvement capacity within people (Improving Inter-professional Team-Based Care for Patient Safety)
Unique RHP ID#: 085144601.1.1 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
Kathleen R. Stevens, RN, Ed D, FAAN
Performing Provider TPI: 085144601

Project Summary:

Provider Description:
The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s):
This project will implement the evidence-based national standard of team performance training, TeamSTEPPS, with healthcare providers across a range of inter-professional disciplines. Following train-the-trainer interventions, quality improvement projects will be performed throughout the region, spreading the team performance training.

Need for the project:
Currently, the lack of team performance training results in communication defects and threats to patient safety and effectiveness of care.

The project seeks to establish a customized for team training (YR 2); train 20 Master Trainers in TeamSTEPPS (YR2=20; YR3-5=30); establish baseline for team attitudes toward team performance (YR2); stimulate improvement projects (implementation of fundamentals training) (YR2=3; YR3-5=15).

Target population:
Healthcare providers in UTHSCSA and within the Region, including physicians, advance practice nurses, clinical nurses, clinic and unit staff, other health professions (e.g., PT, OT), faculty, students, and residents. Primary targets for this project are those providers who service patients throughout the region, particularly through the University Health System (UHS), including hospital and outpatient-based care teams. The project will train a total of 110 Master Trainers who will spread the training through at least 48 quality improvement projects.

It is expected that every patient in the Region stands to ultimately benefit from this project as it produces safer, better team care practices across the hospitals and clinics in the Region. Estimates (see Table 2 below) are that patients proceeding through 20,000 hospitalizations and 1.7 million outpatient visits will benefit from strengthened team performance.

As the providers in the Region practice care with greater team skills, care for these patients becomes safer and more efficient and adverse events resulting from inadequate team
communication and performance are reduced.

Category 1 or 2 expected patient benefits:

The following offers a snapshot of the Medicaid and indigent population that is targeted for safer and better team care, to be impacted through this project. Texas has the highest percentage of uninsured residents in the nation. Bexar County is one of several urban counties in Texas with large public or nonprofit hospitals, the primary of which is the University Health System, that have developed programs for serving a wider range of medical needs for a greater proportion of low-income uninsured.

Table 1. Bexar County 2008 statistics are as follows:

| Population | 1.6 million |
| Hispanic   | 60%         |
| Poor       | 17%         |
| Uninsured  | 1 in 4 adults |

Source: [http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf61567](http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf61567)

Table 2. Regional hospital and outpatient service utilization statistics from 2010 reflect the high proportion of Medicaid and uninsured patients serviced through the UHS, who stand to benefit from the project.

<table>
<thead>
<tr>
<th>Source</th>
<th>Hospital Utilization 20,000 discharges</th>
<th>Outpatient Utilization 1.7 million visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>30%</td>
<td>6%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>Medicare</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>


Category 3 outcomes:

Our goal is to improve scores on the Culture of Patient Safety survey by 5% (YR4 and YR5).

Project Description:

Currently, team-based care is not widely practiced nor broadly taught in healthcare, including our region. The resulting communication defects result in threats to patient safety and effectiveness of care. The major delivery solution is implementation of the evidence-based national standard of TeamSTEPPS team performance training across all healthcare providers in UTHSCSA, including physicians, advance practice nurses, clinical nurses, clinic and unit staff, other health professions (e.g., PT, OT), faculty, students, and residents.

The goal is to customize, implement, and evaluate an innovative evidence-based inter-professional team-based care model to achieve high team performance for patient safety in all healthcare practice settings of the HSC. The target is better care through improved team performance to impact care transitions, team communication, culture of patient safety, and patient satisfaction. We will extend, replicate, and test an innovative evidence-based inter-professional team-based care model to achieve team-based care for patient safety in all healthcare practice
settings of the HSC. The expected outcome target is better care through improved team performance to impact team communication, culture of patient safety, and patient experience.

Outcome: Team-based care will improve quality and safety for patients and families through a number of channels. The 4-year expected outcome resulting from implementation of the project would include greater team-based care effectiveness and cost avoidance from better patient safety and satisfaction with experience. Essential interim outcomes include expanded care provider attitudes and skills in team performance. Training program outcomes include: Sustained team-based care training for professional development (continuing education) for faculty and clinicians; sustained team-based care training in formal inter-professional coursework and clinical practicum settings in which education occurs and improvement projects performed by newly-trained staff.

Challenges faced in promoting team-based skills include assembling inter-professional groups (practicing professionals, faculty, and students) to engage in this training to acquire team-based care skills. The 2 ½ day Master Training and the 4-hour basic training will require dedicated time and effort from these groups and from the trainers. Another challenge noted by others who have implemented TeamSTEPPS on a broad scale is the paradigm shift that must occur to achieve team-based care across disciplines. Often silos and traditional communication/collaboration styles are embedded in team-based care. Finally, the shift by organizations to evolve systems supporting patient safety demands both administrative and frontline provider to effect a culture of patient safety.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

A strong foundation of available resources has been developed over the last 3 years, including 100+ Master Trainers (MT’s) in the TeamSTEPPS program, who will serve as resources to extend the training. The ACE center has experience in planning and implementing the 2 ½ day Master Training and national affiliations (e.g., Agency for Healthcare Research and Quality) to assure the most current training locally. Although these advances have been made in training the trainers, diffusion into clinical settings still lags and sustainment is not yet stabilized. For example, of the MT’s from this program, about 1/3 have moved forward with agency integration; and this group reports scores that have remained low on the AHRQ Hospital Survey on Patient Safety Culture (HSOPS)\textsuperscript{15}. Clearly, the proposed program can contribute to gains in team-based care for patient safety.
Human factors research demonstrates that even proficient professionals are vulnerable to error due to inherent human limitations. High reliability organizations, such as aviation, find that teams of professionals who communicate effectively compensate for individual vulnerability and reduce consequences of errors, resulting in enhanced safety and improved performance. A major finding of the report, To Err Is Human was that inadequate communication was the largest contributing factor to the occurrence of errors and near misses in healthcare. Communication failures have been shown to be the leading cause of sentinel events, including preventable patient deaths, accounting for up to 80% of adverse events. Preventable medical errors in US hospitals cost an estimated 98,000 patient lives and $17 to 29 billion each year.

Accrediting agencies acknowledge that poor team communication in the form of intimidating and disruptive behavior also undermine a culture of safety. In this vein, The Joint Commission established a new leadership standard and as of January 2009, requires sentinel event reporting of disruptive and inappropriate behaviors. Suggested actions include encouragement of interprofessional dialogues across a variety of forums. Preventive measures include standardized communication techniques, such as those contained in teamwork training.

Effective inter-professional teamwork in healthcare is essential to patient safety. Although sparse, research on inter-professional education (IPE) is suggestive that IPE may produce positive outcomes on department culture, patient satisfaction, collaborative team behavior, and reduction of errors. Key IOM recommendations are that healthcare organizations “establish interdisciplinary team training programs for providers that incorporate proven methods of team training…” that all health professionals are educated to deliver care as members of an interdisciplinary team, and that common language and core inter-professional competencies are developed.

The quick response to these recommendations by multiple government agencies produced a standardized team training program based on best evidence: Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS™). This new teamwork system is designed to optimize team performance and outcomes across the health care delivery system. TeamSTEPPS is the standardized federal program for healthcare team training.

In this context, Academic Health Centers have been called on to create positive clinical education environments. Given that approximately 50% of nursing education and 70% of physician education occurs in clinical settings, IOM urges that Academic Health Centers create positive clinical education environments. Our own UTHSC Strategic Plan, Goal #1 targets the provision of an “environment for educational excellence”.

There is an urgent need for standardized training in inter-professional teamwork and communication that moves easily from academic to practice settings. In addition to human factors in systems failures, often the basis of breakdowns in communication is the differing communication styles used by clinicians attributable to differences in education and lack of formal education in teamwork. Every quality improvement intervention, at its core, is targeted at making sure that a team of healthcare workers with various levels of education and often with various agendas come together and coordinate effectively and have some equal teamwork competency and standing. This multidisciplinary nature of the team and its work inhibit the team’s ability to coordinate and communicate effectively. Yet standardized team communication is not typically taught as core competencies in health professions although required or recommended. Few
members of the present workforce have had opportunity to be trained in standardized communication such as TeamSTEPPSTM. Emerging evidence indicates that TeamSTEPPSTM diffusion is correlated with improvement in scores of the AHRQ Hospital Survey on Patient Safety Culture (HSOPS), a system change much needed in most clinical settings.

To our knowledge, no other similar projects funded by the USDHHS are currently underway at UTHSCSA.

**Core Project Requirements:**

(a) Provide training and education to clinical and administrative staff on process improvement strategies, methods and culture.

(b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency, and other issues aligned with continuous process improvement.

A & B represent all core project components listed above are implemented.

The project will train a total of 110 Master Trainers who will spread the training through at least 48 quality improvement projects led by these trainers within 6 months of completion of training. These CQI projects will scale and spread the team performance training in order to drive their entire organizations on a more rapid trajectory of improvement.

CN.1 Enhance quality of care and improve patient satisfaction

**Related Category 3 Outcome Measure(s):**

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions Response to reviewer: Because OD-9 is Right Care, Right Setting, we respectfully submit that OD-4 remains the most closely aligned.

IT-4.10 Other Outcome Improvement Target Enhance Improvement Capacity within people (Improving Inter-professional Team-Based Care for Patient Safety)

Measure for Category 3 outcomes: Performance improvement for culture of patient safety. Appropriate Care that is Safe; Improved Clinical Performance Outcomes in terms of care team performance. Outcome: Team-based care will improve quality and safety for patients and families through a number of channels. The 4-year expected outcome resulting from implementation of the project would include greater team-based care effectiveness and cost avoidance from better patient safety and satisfaction with experience. Essential interim outcomes include expanded care provider attitudes and skills in team performance. Training program outcomes include: Sustained team-based care training for professional development (continuing education) for faculty and clinicians; sustained team-based care training in formal inter-professional coursework and clinical practicum settings in which education occurs and improvement projects performed by newly-trained staff.

**Relationship to other Projects:**

1.1 Expand Primary Care Capacity Dr. Julie Cowan Novak
1.2 TeamSTEPPS is a program whose ultimate objective and purpose is improved patient safety and as such reinforces, enables, and is related directly to most other projects or at a minimum indirectly to all others. The direct application of newly-developed modules and metrics makes TeamSTEPPS relevant to ambulatory care settings and patient engagement. In every setting that offers care through team-based processes, TeamSTEPPS is essential.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The objective of this project is to improve patient safety via tools and training centered around quality. As a result it is directly related to all other projects.

**Plan for Learning Collaborative:**

A learning collaborative will be formed such that organizations are able to share ideas, challenges and develop solutions. The learning collaborative will bring participating sites together via conference call once a quarter where project-level goals are discussed and other projects are able to learn. A face-to-face meeting will occur once a year at the CTSA CER meeting where informatics is the topic of discussion. During this meeting, those belonging to the learning collaborative along with others outside of the region are able to share knowledge and participating sites are able to learn from the successes/challenges of other sites.

**Project Valuation:**

Because a healthcare setting’s culture of patient safety is demonstrated to be directly related to prevention of healthcare associated harm and reflects higher organizational just cultures, teams that hold strong allegiance to high team performance are crucial within the context of the high reliability organization. The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.

The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
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<th>Outcome Measure(s)</th>
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<th>1.10.1 (A, B)</th>
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<td>TPI - 085144601</td>
<td>085144601.3.1</td>
<td>3.IT-4.10</td>
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### Year 2
(10/1/2012 – 9/30/2013)

#### Milestone 1
P-2. Establish a customized program for trained experts on process improvements to mentor and train other staff for safety: Project planning, stakeholder engagement. Lead improvement projects.

- **P-2.1 METRIC** Train the trainer program established
  - Numerator: 20 staff trained as TeamSTEPPS Master Trainers
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 20 staff = 440 hours of training.

#### Milestone 2
P-2. Implement the training program; ongoing training will increase capacity for QI.

- **P-2.1 METRIC** Number of staff trained as TeamSTEPPS Master Trainers
  - Numerator: 30 staff trained as TeamSTEPPS Master Trainers; Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

#### Milestone 3
P-2. Implement the training program; ongoing training will increase capacity for QI.

- **P-2.1 METRIC** Number of staff trained as TeamSTEPPS Master Trainers
  - Numerator: 30 staff trained as TeamSTEPPS Master Trainers; Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

### Year 3
(10/1/2013 – 9/30/2014)

#### Milestone 2
P-2. Implement the training program; ongoing training will increase capacity for QI.

- **P-2.1 METRIC** Number of staff trained as TeamSTEPPS Master Trainers
  - Numerator: 30 staff trained as TeamSTEPPS Master Trainers; Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

- **P-2.2 METRIC** Improvement projects led by newly trained staff
  - Numerator: 15 projects
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

- **P-2.2 METRIC** Improvement projects led by newly trained staff
  - Numerator: 15 projects
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

### Year 4
(10/1/2014 – 9/30/2015)

#### Milestone 3
P-2. Implement the training program; ongoing training will increase capacity for QI.

- **P-2.1 METRIC** Number of staff trained as TeamSTEPPS Master Trainers
  - Numerator: 30 staff trained as TeamSTEPPS Master Trainers; Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

- **P-2.2 METRIC** Improvement projects led by newly trained staff
  - Numerator: 15 projects
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

### Year 5
(10/1/2015 – 9/30/2016)

#### Milestone 5
P-2. Implement the training program; ongoing training will increase capacity for QI.

- **P-2.1 METRIC** Number of staff trained as TeamSTEPPS Master Trainers
  - Numerator: 30 staff trained as TeamSTEPPS Master Trainers; Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

- **P-2.2 METRIC** Improvement projects led by newly trained staff
  - Numerator: 15 projects
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training

- **P-2.2 METRIC** Improvement projects led by newly trained staff
  - Numerator: 15 projects
  - Denominator: NA
  - Data Source: Training program records: 22 hrs/staff person is required for completion; 30 staff = 660 hours of training
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<tr>
<th>Milestone</th>
<th>Estimated Incentive Payment</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$406,800</td>
</tr>
<tr>
<td>2</td>
<td>$446,717</td>
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<tr>
<td>3</td>
<td>$238,942</td>
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<tr>
<td>4</td>
<td>$230,862</td>
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<tr>
<td>5</td>
<td>$230,862</td>
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**Milestone 1**

Estimated Incentive Payment

**Milestone 2**

Estimated Incentive Payment

**Milestone 3**

Estimated Incentive Payment

**Milestone 4**

I-X Establish impact of training on team performance and culture of patient safety.

I-X-1 METRIC Average of 5\% gain of cohort on team performance (difference on newly trained staff)

**Milestone 5**

Estimated Incentive Payment: $230,862

**Milestone 6**

I-X Establish impact of training on team performance and culture of patient safety.

I-X-1 METRIC Average of newly trained staff

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P-2.2. Numerator: 3 projects led by trained staff.
Denominator – Number of Master Trainers to date for the year.

Data Source: Documentation of improvement projects including TeamSTEPPS fundamentals training offered by newly-trained Master Trainers.

Milestone 1 Estimated Incentive Payment

$406,800

P-2.2. Numerator: 15 projects led by trained staff.
Denominator – Number of Master Trainers to date for the year. (Master Trainers implementing ‘fundamentals’ training in an agency or testing impact of TeamSTEPPS.)

Data Source: Documentation of improvement projects including TeamSTEPPS fundamentals training offered by newly-trained Master Trainers.

Milestone 2 Estimated Incentive Payment

$446,717

Milestone 3 Estimated Incentive Payment:

$238,942

Milestone 4

I-X Establish impact of training on team performance and culture of patient safety.

I-X-1 METRIC Average of 5\% gain of cohort on team performance (difference on newly trained staff)

Milestone 5  Estimated Incentive Payment:

$ 230,862

Milestone 6

I-X Establish impact of training on team performance and culture of patient safety.

I-X-1 METRIC Average of newly trained staff

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UTHSCSA
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<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $406,800</th>
<th>Year 3 Estimated Milestone Bundle Amount: $446,717</th>
<th>Year 4 Estimated Milestone Bundle Amount: $477,883</th>
<th>Year 5 Estimated Milestone Bundle Amount: $461,723</th>
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<td>Pre and Post scores on trainee-reported AHRQ Teamwork Attitudes Questionnaire</td>
<td>5% gain of cohort on team performance (difference on Pre and Post scores on trainee-reported AHRQ Teamwork Attitudes Questionnaire)</td>
<td>Milestone 4 Estimated Incentive Payment: $238,942</td>
<td>Milestone 6 Estimated Incentive Payment $230,862</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,793,123**
Identifying Project and Provider Information:

Title: 1.3.1 Implement/enhance and use chronic disease management registry functionalities (Longitudinal Diabetes and Other Chronic Disease Registries to Improve Patient Outcomes)
Unique RHP ID#: 085144601.1.2 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Project Summary:

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): This project will develop longitudinal clinical registries to improve quality of care at our collaborating primary care practices that train medical students and residents in medicine and will implement evidence-based community health worker (promotora) interventions to address health risks in patients who are not meeting their disease management goals.

Need for the project: This project serves as a basis for many other initiatives to improve the quality and outcomes of patient care by developing longitudinal clinical registries to help primary care physicians evaluate their care and identify patients who are in need of support to improve outcomes. Our study population is majority Latino with a large proportion who receive care through CareLink, a county-based financial assistance program. We will offer valuable data about predictors of poor achievement of clinical care goals such as uncontrolled hypertension, poor control of diabetes, and excessive weight gain. These are all associated with the development of complications that can compromise quality of life and survival as well as increase the need for costly urgent care services including admission/readmissions and emergency department utilization. In addition, this project will contribute to a coordinated care delivery system and improve outcomes while containing cost growth through evidence-based interventions for patients who do not meet quality of care metrics. Through electronic medical record-derived registries, we will be able to examine the continuum of care across ambulatory primary care providers and specialists, and hospital admissions as well as laboratory and procedures performed in these linked systems of care.

Target populations: We will focus our project on improving outcomes of low income patients with Medicaid, CareLink (county-funded financial assistance), and no insurance who are not meeting quality of care, health maintenance goals or requiring treatment with narcotics for pain. We will first target individuals with diabetes mellitus who have a mean hemoglobin (Hb) A1C level of >= 7.5% which increases the patients’ risk of diabetes complications. Second, we will identify a similar cohort of persons who have sustained uncontrolled systolic hypertension, which is the dominant form of uncontrolled hypertension. Third, we will identify persons who have chronic non-cancer pain and are treated with narcotics long-term since these individuals are known to be heavy users of emergency and hospital services as well as at risk for overdose events. Finally, we will identify HIV-infected persons in our local HIV clinic who have Ryan White or CareLink insurance because we have found that over 60% are overweight or obese and are still having significant weight gain.

Category 1 or 2 expected patient benefits:

DY 2: Patient Navigation (2.9): This project will target over 1,000 patients who fail to achieve health maintenance and disease management goals at three clinics. Once these patients are identified, we will
train and guide 5 patient navigators (promotoras) and peers from the practice to assist the patients at
greatest need with culturally appropriate interventions and provide at-risk patients with coordinated,
timely, and site appropriate health care services.

DY 3: By improving patient navigation, the patient experience (2.4) will also be improved.
Enhancement/Expansion of Medical Homes (2.1): Central to successful medical homes is access to
excellent information about quality of care metrics and insuring well-coordinated, comprehensive care.
Longitudinal chronic disease registries provide a foundation for these goals. Our goal is to have all key
personnel at the Brady Green clinics understand how to read and use the registry by the end of year 5.

DY 4: Expansion of Chronic Care Management Model (2.2): By using a longitudinal study design, this
project will provide comprehensive information on how patients use and receive services over time – so
that we can identify those who have not been seen within a recommended timeframe to evaluate their
chronic disease status. We can also examine patterns of care. A key predictor of poor outcomes in our
prior research on patients with diabetes in our primary care clinics at University Health System is the
proportion of scheduled visits that a patient keeps (% visit non-attendance). We have found that patients
who fail to keep scheduled visits in a baseline three-year period are at increased risk of hospitalization in a
follow-up year – with a two-fold greater risk of hospitalization for persons who keep only 60% of
scheduled visits compared with patients who keep >75% of visits (absolute difference 6% vs. 13%,
respectively) after adjusting for patient demographic, clinical, and health care variables. We have also
found that the % visit non-attendance is also linearly associated with less reduction in hemoglobin A1c
(HbA1c) among patients who have a baseline HbA1c >8%. Sustained HbA1c over 8 is associated with an
increased risk of avoidable complications in the long term including renal failure, blindness, and vascular
diseases. In all of these analyses, 50-60% of these patients have CareLink or Medicaid insurance and most
are Latino. For our DSRIP project, we will be able to examine the pattern of visit non-attendance among
patients in our cohorts and then stratify on baseline poor control to target patients who need additional
promotora support along with proactive practice-based interventions. We aim to have >98% of active
patients have documented HbA1c as well as documentation as to why they are not on medication if they
HbA1c is over 6.5%. We will also look for all patients with hypertension to have documented blood
pressures at least twice a year. We also have approximately 5% of our 1433 patients in HIV clinic who
have fewer than two BMI measurements. We aim to have all HIV patients have BMI recorded at visits at
least twice a year. Finally we are looking to see documentation of a urine drug screen and an opioid use
agreement for at least 60% of patients on long-term narcotics. Goal is to increase the percentage of
patients with diabetes in the registry by 5%. Our goal is to have a complete updated registries for patients
with hypertension, long-term opioids (defined as at least 90 days in a 6 month period), and HIV infection.
Lastly, our goal is to have reached 95% of the providers in the Brady Green Clinic with educational
materials about the interventions and educate them about providing all patients with disease specific
information to overcome barriers to achieving goals.

DY 5: Redesign for Cost Containment (2.5): This project will allow us to investigate if patients receive
either too many or not enough services. By examining these areas, we can also offer feedback to
physicians about their level of service utilization relative to other providers (e.g. too many MRIs for low
back pain or too few patients immunized against pneumococcal vaccine). For example, we will focus on
our chronic non-cancer pain registry in identifying patients who are receiving high dose opioids or
prescriptions without being seen in the office because they have excess utilization of emergency room and
hospital services. Reports will be generated for over 75% providers/care teams for care delivered outside
the office visit. Our goal is to reduce the mean A1c to <7.3 for these patients using an outreach
intervention. We can expect to substantively improve blood pressure control in this population from an overall mean of 135 mmHg to 131 mmHg. Lastly, we will work to reverse the observed rapid weight gain to <1% BMI per year. For patients with chronic pain on narcotics, our goal is to have 80% receive urine drug testing at least once a year and 80% have documented opioid use agreements. We will also monitor the morphine equivalent doses for these patients and offer feedback to 100 percent of the providers about the risks of doses over 50 per day.

Category 3 outcomes: This project will address Outcome Dimension 11: Addressing Health Disparities in Minority Populations, specifically Improvement in Clinical Indicators in Latino Populations. The clinical indicators chosen for this project include hypertension control, HbA1c reduction to goal, and stabilization of weight in HIV infected patients who are overweight or obese. We will also work to improve our non-attendance rate for our patients. Currently, the mean non-attendance rate for our diabetes population is 31%. For persons with diabetes and mean HbA1c >= 7.5%, efforts to reduce this level to < 7.5% are most cost-effective according to the American Diabetes Association. We propose to first target persons with baseline A1c and a last A1c mean 7.5% reduce their mean to <7.5%. In terms of hypertension, the goal of this project is to insure that the majority of our Latino population meets targets for blood pressure control, including <140 mmHg systolic blood pressure for non-diabetics and ideally <130 Hg for diabetics We will reduce the proportion of patients who have uncontrolled hypertension despite drug therapy by 10% and achieve at least a 3-5 mmHg reduction in systolic blood pressure. We will use our registries to define patients who need support to achieve goals and implement evidence-based promotora and peer support interventions to address these health risks.

For patients treated with long-term narcotics, our goal is to offer additional support to reduce the proportion of patients who meet quality of care metrics including, visits every 3-6 months, urine drug screening, opioid agreement, and morphine equivalent dose <50. In other analyses in an insured population, our group has found that patients with chronic non-cancer pain who have are prescribed high dose long-term opioids have 8 times the risk of hospitalization compared with those on no opioids. Our group has also examined weight gain as an adverse outcome for patients with HIV infection and found that those who are from minority groups (Latino or non-Hispanic black) with no insurance (CareLink or Ryan White) have 8 times greater risk of gaining more than 3% of their BMI annually vs. non-Hispanic whites with Medicaid or Medicare insurance. This results in a rapid rise in the obesity; among 455 overweight (BMI 25 to 30) HIV patients at baseline, 25% will become obese (BMI=>30) within only 3 years and among 491 normal BMI (19-25), 9% will become obese in 3 years. We must address this additional risk factor for complications in HIV-infected persons.

Project Description:
The University of Texas Health Science Center at San Antonio (UTHSCSA) and our practices in collaboration with University Health System (UHS) are well positioned in our region to address the DSRIP category I project area 1.3 “Implement a Chronic Disease Management Registry”. We are already engaged in developing registries to support effective care management. University Health System has each initiated longitudinal Diabetes Registries to inform delivery of care, to educate providers and patients, and to target disease management interventions that will improve quality of care and clinical outcomes in the population we serve. The first specific aim of this project is to create a quality improvement (QI) data mart for the outpatient management by UT primary care and HIV practices located at UHS Brady Green campus for patients with diabetes, hypertension, HIV, and patients with chronic pain treated with opioids. A second specific aim is to assist with building a parallel data mining resource for University Health System clinics because we share many of the same patients. We are in the process of developing a Health Information Exchange (HIE) to ensure seamless exchange of information
about our patients. A third specific aim is to use these data to inform providers and patients about care outcomes and to offer a resource to target and evaluate case management and other interventions to improve outcomes when needed.

**Challenges.** Major professional societies and international public health organizations including the World Health Organization and the American Diabetes Association endorse targeting diabetes as a key health care threat. Our goal is to reduce the significant adverse impact of diabetes not only on our patients but on our community because it can be a very costly, high morbidity condition. The other conditions that we are targeting have similar serious consequences for our community: a) hypertension - the main cause of cardiovascular disease that, in turn, is the most common cause of death in adults in our region, b) HIV - a deadly condition that has been transformed into a chronic disease if given excellent care, and c) chronic pain management with opioids -- can lead to diversion and overdose when care is not well monitored and coordinated.

**Approaches to Address Challenges:** Using diabetes as our model for a registry, it is critical that providers receive information about quality of care indicators, longitudinal patterns of care (e.g., examining adherence to scheduled appointments), adherence to medications, and clinical outcomes as defined by hemoglobin (Hb) A1c and renal function to avoid complications such as diabetes-related renal disease and blindness. The diabetes registry should be the backbone for population management to identify at-risk persons within a defined population and to provide specific patient support strategies for these persons who are failing to achieve care goals, directed by the patient’s usual source of care through a clinical nurse case manager and case management team. Feedback to providers based on periodic registry review will be conducted to insure that these outreach patient support programs are effective.

**5-year outcomes include:** 1) Improvement in the proportion of registry patients who receive recommended services; 2) Improvements on lab results including but not limited to: HbA1c tests and lipid tests; and 3) documentation of patient-specific goals, and reduction in urgent care services. Currently, we have identified 6,780 patients followed in the Family Medicine clinic at the Brady Green Building at UHS who have CareLink, Medicaid, or self-pay, of whom 24.7% have diabetes. Currently we have identified 1,171 patients followed in the General Internal Medicine clinic at the Brady Green who have CareLink, Medicaid, or self-pay, of whom 39.1% have diabetes. Similarly, the proportions of patients in these two clinics with hypertension are 38.8% and 64.4%, respectively. The HIV clinic at the Brady Green currently follows approximately 1,200 patients. By tracking various chronic disease metrics (e.g. HbA1c, lipid, weight, exercise frequency), we will be able meet patient-specific goals by targeting patients in need of support by promotoras and peers to address deficiencies in care such as poor medication adherence and unhealthy lifestyle, thereby improving clinical status and reduce urgent care utilization consistent with the region 6 waiver goals of: meeting CMS stated triple aim goals of assuring patients receive high quality patient centered care, in the most cost effective ways. In addition this project improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties, further develops and maintains a coordinated care delivery system, and improves outcomes while containing cost growth.

**Starting Point/Baseline:**

The data source for the diabetes registry is Sunrise electronic medical record that serves all of the clinics located at a UHS site – for UT Medicine clinics the site is the Brady Green campus. In this project, we are serving three clinics at UHS that have large numbers of Medicaid, CareLink or self-pay patients. The guiding principle of this project is to develop a centralized analytic system that offers a centralized data repository, technology and knowledge management. We will establish an analytics/data mining center of excellence that creates, implements and maintains longitudinal registry databases of health care utilization and services for patients with common chronic diseases and ambulatory care sensitive conditions. UT Medicine has over 30 primary care providers, including residents and faculty as well as allied health
professionals (nurse practitioners, physician serving patients in these settings)

Currently, the Brady Green diabetes registry for the UT Medicine practices has over 2,000 persons from 2011-12 with longitudinal data on demographics, health care utilization, vital signs (e.g. BMI), clinical lab measures (e.g. HbA1c), prescribed medications, and other comorbidities. We are working to improve this registry by developing improved, more complete data queries, by reducing missing or incomplete data elements, and by linking patients to their usual source of care. No formal provider training has been undertaken on the use of this registry. This needs to be completed to ensure that physicians/allied health personnel and their support staff can use the registry data properly and to its fullest capacity. The HIV registry from 2008-2011 includes over 1,500 persons who have been validated by chart review as having this infection. Our database includes all encounters, diagnoses, relevant HIV tests, vital signs (validated), medications, insurance and demographics. We plan to train all providers at Brady Green primary care practices to use the data in the registry and, in order to improve clinical outcomes, to direct promotoras and peers to help patients who are not achieving quality of care goals.

Rationale:

Reasons for Selecting Project: This project serves as a basis for many other initiatives to improve the quality and outcomes of patient care. It meets all the Triple Aim goals by assuring that patients receive high-quality and patient-centered care and in the most cost effective manner. Our providers serving an indigent population including persons with Medicaid, CareLink, and no insurance. We will offer valuable data to inform implementation of patient support and practice procedures that will improve patient clinical outcomes such as reduced HbA1c, systolic blood pressure and weight control – all of these factors are associated with increased use of health care resources and preventable complications when not controlled to nationally accepted goals. We have plans to unite the University Health System (UHS) and UT Medicine electronic medical record systems through a Health Information Exchange called DBMotion. However, even before the HIE is implemented, we are able to examine the continuum of care across ambulatory primary care providers and specialists, hospital admissions as well as laboratory and procedures performed in these linked systems of care. In addition, this project will further develop and maintain a coordinated care delivery system and improve outcomes while containing cost growth. This project addresses Categories 1.3, 2.9, and 3 Outcome Dimension 11.

The following project Required Core Project Components are included in the milestone and steps to achieve milestone sections below:

(a) Enter patient data into unique chronic disease registry.
(b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
(c) Use registry reports to develop and implement targeted QI plan.
(d) Conduct quality improvement for project using methods such as rapid cycle improvement.

Milestones:

DY 2: Identify one or more targeted patient populations diagnosed with selected chronic disease(s). For the diabetes registry, various data elements will be extracted from the EMR: 1) patient encounters, 2) diagnosis codes from problem lists, medical history and encounters, 3) lab orders and results, 4) necessary services (e.g. immunizations, eye examination) – all stored in different tables in the Sunrise electronic medical record database that will be linked to provide comprehensive longitudinal data on patient care. For the hypertension and HIV registries, elements extracted include demographics, BMI, blood pressures, arrival status of visits, relevant labs, disease specific medications, comorbidities, providers, ER use, and hospitalization.
DY 2: Develop cross-functional team to evaluate registry program
DY 2: Implement/expand a functional disease management registry
DY 3: Undertake provider training to prepare practices and providers to use the registries to evaluate/inform patient care, target outreach, and evaluate outcomes of initiatives to improve patient care.
DY 3: Conduct staff trainings on populating and using registry functions
DY 3-5: Case manager/promotora, peer coaches, and associated team members will use this registry to coordinate services for at risk patients in collaboration with the usual source of care.
DY 4: Increase the percentage of patients with diabetes based on billing data from UT Medicine (N=2121) recorded in the registry (that currently has 2005) by 5% by searching UHS electronic medical records for patients who are not yet in the registry
DY 5: Generate registry-based reports for each provider/care team for the care delivered outside the office visit.
DY 5: Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease or MCCs to over 80%

Steps to achieve milestones
- Microsoft SQL Server Database will be accessed from SAS on Microsoft Windows, using ODBC (Open Database Connectivity and data will be imported to SAS.
- SAS programs will be written for definitions of established patient, assigned physician, diagnosis of diabetes, last HbA1c, last LDL cholesterol as well as more complex variables including the proportion of scheduled visits that were attended (low proportion = high risk), and adherence to medications.
- The accuracy of data will be assessed by manual verification of selected patient records and, when necessary, the process of data extraction and import will be modified to improve accuracy.
- Once fully functional, SAS will continually generate reports for physicians caring for patients with diabetes in UT Medicine and their UHS administrators and other team members. Further, reports will be generated for providers to alert them when certain goals need to be addressed.
- The ‘at-risk’ outliers not achieving therapeutic goals will be identified and “red-flagged.”
- A case manager and case management team will be hired and trained with the goal of periodically reviewing the red-flagged patients with the physicians and care team independent of scheduled visits.
- Outreach project will be designed and implemented to contact and communicate with these outliers and evidence-based interventions implemented to assist them to achieve their therapeutic goals.
- We hypothesize that an iterative intervention by a “population manager,” who would identify at risk patients and collaborates with the physician as well as the patient to address barriers to success could potentially result in significantly better overall diabetes management compared with a population of patients receiving usual care. Similar potential for improvement is possible for the other chronic disease that we will target.

Metrics for Diabetes Registry as an example
Year 1. Develop/implement a registry, hire and train staff in use of registry.
Year 2. 50% - 70% of patients with diabetes are entered in the registry.
Year 3. 60%-80% of patients with diabetes are entered in the registry
50%-60% of physicians receive monthly registry reports on their patients with diabetes.
Year 4. 60%-80% of physicians receive monthly registry reports on their patients with selected conditions.
50% - 60% of physicians communicate periodically via face-to-face meeting, teleconference or electronically with panel manager and care team to red-flag patients to receive outreach by phone, mail or in-person.  

75% - 100% of physicians receive monthly registry reports on their patients with selected conditions. 60% - 80% of physicians communicate periodically via face-to-face meeting, teleconference or electronically with panel manager and care team to red-flag patients to receive non-physician outreach by phone, mail or in-person.

**Community Need:** This project has great potential to address community needs defined in the Community Health Improvement Plan for Bexar County. Specifically, we will address priority areas of Healthy Eating and Active Living (#1) as well as Behavioral and Mental Well-Being (#4). Health issues addressed by identifying patients with diabetes, HIV, and hypertension who require additional services to meet lifestyle and care goals. In regard to Behavioral and Mental Health, patients who do not achieve chronic disease management goals are significantly more likely to have unmet behavioral and mental health support needs. A key component of our outreach support and services for at risk patients who are identified from the registry will be offering formal (promotora) and informal (peer support) as needed to address these health care needs.

CN.2 is the unique community need being addressed by this project.

**Related Category 3 Outcome Measure(s):**

OD-11 Addressing Health Disparities in Minority Populations.

[IT-11.2]: Improvement in disparate health outcomes for target population, including identification of disparity group

(IT-11.1]: Improvement in Clinical Indicator in identified disparity group. Improvement in clinical indicators of hypertension control, HIV viral load suppression, hemoglobin A1C in both Hispanic and non-Hispanic populations but reductions are expected to be greater in the former group because poorer status at baseline

Related to Category 3 Outcome Measures, this project will address Outcome Dimension 11: Addressing Health Disparities in Minority Populations, specifically Improvement in Clinical Indicators in Latino Populations. The clinical indicators chosen for this project include hypertension control, Hb A1C reduction to goal, and HIV care goals of reducing excessive weight gain in persons who are overweight or obese. These measures are a priority for the RHP because research and national surveys conducted by the CDC have shown that low-income, Hispanic populations are disproportionately affected by poor clinical and functional status reflecting poor achievement of chronic disease management goals and a high prevalence of overweight and obesity. Thus, morbidity and chronic disease management are areas of great concern for providers working with Latinos. In terms of hypertension, the goal of this project is to improve our data entry and registry accuracy so that valid blood pressure data are recorded for at least 90% of our Latino population. For persons with a mean HbA1c over 7.5, efforts to reduce this level to under 7.5 is not only cost-effective but also significantly reduces the risk of diabetes complications when <7% according to the ADA. We propose to reduce the mean HbA1c from the current 7.7% in our study practices to 7.3 (5% absolute reduction) by targeting the persons who fail to keep their appointments and
who have elevated HbA1c. Currently, we have found that the average relative reduction over a three year period in HbA1c for persons with an HbA1c over 8% at baseline is -15.9% for persons who keep >75% of visits vs. only -9.5% for persons who keep <60% of visits. Similarly, we will reduce the proportion of patients who have uncontrolled hypertension despite therapy by 10% and achieve at least a 3 to 5 mmHg reduction in systolic blood pressure. We will be able to achieve these goals by using the registry to define patients who need additional support to achieve goals and to implement evidence-based community health worker (promotora) interventions to address these health risks through promotoras and peer support. In collaboration with the patient practices, promotoras and trained peers will provide culturally appropriate outreach aimed at reducing disparities for low-income and Hispanic patients. To address health disparities, Dr Turner led a successful randomized controlled trial of peer support for uncontrolled hypertension in a minority population that resulted in a reduction in systolic blood pressure similar to adding a new drug (Turner, et al. 2012).

### Relationship to other Projects:

In relation to other projects and interventions within the RHP plan, this project supports, reinforces and enables Patient Navigation, Redesign to Improve Patient Experience, Enhancement/Expansion Medical Homes, Expansion of Chronic Care Management Models, and Redesign for Cost Containment.

**Patient Navigation (2.9):** This project will target patients who fail to achieve health maintenance and disease management goals. Once these patients are identified, we train and guide patient navigators (promotoras) and peers to assist the patients at greatest need and provide at-risk patients with coordinated, timely, and site appropriate health care services. By improving patient navigation, the patient experience (2.4) will also be improved.

**Enhancement/Expansion of Medical Homes (2.1):** Central to successful medical homes is access to excellent information about quality of care metrics and insuring well-coordinated, comprehensive care. Longitudinal chronic disease registries provide a foundation for these goals.

**Expansion of Chronic Care Management Model (2.2):** By using a longitudinal study design, this project will provide comprehensive information on how patients use services over time – so that we can identify patients who have not been seen within a recommended timeframe to evaluate their chronic disease status. We can also examine adherence to medications and patterns of care. Patients who receive only urgent care can be identified as well as those who persistently cancel or no show to scheduled appointments. These patients are in particular need of targeted management and support programs.

**Redesign for Cost Containment (2.5):** This project will allow us to investigate if patients receive either too many or not enough services. By examining these areas, we can also offer feedback to physicians about their level of service utilization relative to other providers (e.g. too many MRIs for low back pain or too few patients immunized against pneumococcal vaccine).

Related to Category 3 Quality Improvement of Chronic Disease, this project especially focuses on diabetes to ensure that patients who have a mean HbA1c >7.5% and who keep <75% of their visits (associated with an increased risk of adverse events and end organ damage) receive outreach to improve control of their diabetes. We also aim to target patients who continue to have uncontrolled systolic hypertension (>140 mmHg) on treatment. HIV registry data will be used to identify patients who are overweight or obese and work to reduce their rate of weight gain. We have observed a 3% annual increase in BMI in 34% for the 434 HIV infected persons in our registry who are Hispanic or black and who have CareLink or Ryan White insurance and 18% for the 496 Hispanic or Black patients with Medicaid or Medicare insurance. Through culturally appropriate outreach by promotoras and peers, this project aims to reduce disparities for low-income and Hispanic patients. Our primary goals are to improve diabetes and hypertension control and reduce the rate of weight gain for these patients. These are secondary outcome
metrics that we will monitor and expect to see reductions blood pressure, cholesterol, and hyperglycemia that are all related to obesity. We are also going implement team based care programs to improve quality of care metrics for patients who are treated with long-term narcotics for chronic non cancer pain – approximately 100 patients – including record of an opioid use agreement, yearly urine drug testing, and at least one visit every 6 months.

Related to **Category 4 Population-Focused Measures**, this project targets a low-income, Medicaid, and uninsured population because University Health System is our region’s safety net institution and provides care to a largely indigent population. UT Medicine primary and specialty care to these patients. This is a high priority patient population—largely minority (Mexican-American) and low income. These patients are in great need of targeted support to improve health outcomes – this effort will be informed by these longitudinal chronic disease registries.

**Relationship to Other Performing Providers’ Projects in the RHP:**

Other groups with RHP proposals that have similar projects to our implementation of a chronic disease management registry will be asked to form a learning collaborative. These providers include University Hospital who is a central partner in this shared registry and patient support program, Baptist Medical Center that shares many patients with UT Medicine, and San Antonio Metropolitan Health District that supports all efforts to improve the health of our region’s population. Currently, UTHSCSA has a close working relationship to University Hospital through several projects and through its support of our Center for Research to Advance Community Health. Many of the faculty members at UTHSCSA are also providers at University Hospital. Baptist Medical Center is a partner in providing health care and has been very supportive of UT Medicine initiatives such as a new regional children’s hospital. The San Antonio Metropolitan Health District is a close partner of UT Medicine on projects as well as in sharing data on the health status of our residents.

**Plan for Learning Collaborative:**

The learning collaborative will be formed such that organizations are able to share ideas, challenges and develop solutions. The learning collaborative will bring participating sites together via conference call once a quarter where project-level goals are discussed and other projects are able to learn. A face-to-face meeting will occur once a year at the CTSA CER meeting where informatics is the topic of discussion. During this meeting, those belonging to the learning collaborative along with others outside of the region are able to share knowledge and participating sites are able to learn from the successes/challenges of other sites. Metrics will be used to measure success of the learning collaborative (e.g. Network affinity, rate of spread). We propose to develop linkages to other groups around the country that have developed registries to learn from their experiences and to guide our initiatives to improve clinical outcomes: these include the UT Houston (Dr. Bernstam), UT Southwestern (Dr. Halm); University of Pennsylvania (Dr. Day); and MGH (Dr. Atlas).

**Project Valuation:**

**Achieves Waiver Goals:** This project assures that patients on Medicaid, CareLink or self-pay --will receive evidence-based patient-centered care with high value services that will ultimately reduce the risk of complications of these chronic diseases and thereby reduce use of costly urgent care services and reduce unnecessary tests/services. Previous research on the effectiveness of patient registries show that they facilitate identification of at-risk patients and, for diabetics, can direct programs to help patients met HbA1c control goals and reduce complications as well as costs of care.

**Address Community Need(s):** This project addresses community priority needs described in the Community Health Improvement Plan for Bexar County for: Healthy Eating and Active Living and
Behavioral and Mental Well-Being. Priority health issues addressed by this project include diabetes, obesity and hypertension. Registries are increasingly adopted nationally to effectively characterize patient health care needs and respond with appropriate interventions. Through the diabetes and other registries, we will make this unique resource available to providers and patients in order to guide efforts to achieve the goals of the Community Health Improvement Plan for Bexar County.

**Project Scope:** All the proposed database registries will include approximately 10,000 patients and 30 providers. Providers who are recruited and trained in using these data will be more empowered to improve patient outcomes by targeting interventions and support to those who need it most. The cost of diabetes is high (as of 2007, $91.8 billion in direct costs and $39.8 billion spent on indirect expenses) and rising. Previous research estimates costs will be decreased if we are able to decrease hemoglobin A1c in patients with comorbid heart disease and hypertension from an average of 9 to 10% to an average of 6% to 7% (a $2,536 cost differential accrued over 3 years) (Gilmer TP, O'Connor PJ, Rush WA, et al., 2005). Similarly to diabetes, obesity and hypertension also have high costs. Costs attributable to overweight and obesity in Texas in 2001 totaled $10.5 billion including $4.2 billion in direct costs for health care, $5.2 billion in indirect costs for lost productivity due to mortality and $1.1 billion in indirect costs for lost productivity due to morbidity (Texas Department of State Health Services, 2004). In 2010, hypertension was projected to cost the United States $93.5 billion in health care services, medications, and missed days of work. (Heidenreich, Trogdon, Khavjou, Butler, Dracup, Ezekowitz, et al., 2011).

**Project Investment:** The expected investment in this program for Human Resources will include the cost of trainers, promotoras, project coordinator and the data mining team. Equipment purchase and maintenance will be covered by our accompanying project to develop a Health Information Exchange – making this a relatively cost-effective project. The time to implementation of updated diabetes and HIV registries will be one year which will be used to complete the registry and hire and train staff in use of the registry. Subsequent hypertension registry will be completed in year 2-3 and staff trained by year 4. Several organizational priorities will be met by the development of these longitudinal chronic disease registries but the most important is to insure that we provide comprehensive, value-based care that improves the health of the vulnerable populations that we serve.

<table>
<thead>
<tr>
<th>Category</th>
<th>Project Area</th>
<th>Waiver Goals</th>
<th>Community Needs</th>
<th>Project Scope</th>
<th>Project Investment</th>
<th>Value Weight of Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Longitudinal Chronic Disease Registries</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5 (i.e. very cost effective)</td>
<td>20</td>
</tr>
<tr>
<td>085144601.1.2 PASS 1</td>
<td>1.3.1</td>
<td>1.3.1 A-D</td>
<td>1.3.1 IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE MANAGEMENT Registry Functionalities/(Longitudinal Diabetes and Other Chronic Disease Registries to Improve Patient Outcomes)</td>
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<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.2 085144601.3.3</td>
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<tr>
<td>Improvement in clinical indicator in identified disparity group Improvement in disparate health outcomes for target population, including identification of the disparity gap</td>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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<tr>
<td>Milestone 1 [P-1] Identify one or more target patient populations diagnosed with selected chronic disease(s) (diabetes, HTN, HIV, chronic pain on narcotics) or with Multiple Chronic Conditions (MCCs). Metric [P-1.1]: Documentation of patients to be selected for each the registry Data Source: Electronic medical record – administrative database registry reports Milestone 1 Estimated Incentive Payment: $457,650</td>
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<tr>
<td>Milestone 5 [P-5]: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, identify patients in need of services or not at goal, and preventive care status Metric 1 [P-5.1]: Documentation of registry automated report Baseline/Goal: Diabetes database now has over 2,000 Medicaid, CareLink, and self-pay patients at the Brady Green with our goal to develop continuously updated information on A1c, visit adherence, and other diabetes quality of care metrics – LDL</td>
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<tr>
<td>Milestone 9 [P-9]: Implement an electronic process to correctly identify number or percent of screening tests that require additional follow up Metric 1 [P-9.1]: Documentation of an electronic process to correctly identify number or percent of screening tests that require additional follow-up Baseline/Goal: Currently, only 92% of the patients with diabetes in our primary care clinics (N=2026) have a documented HbA1c in the past two years and not all patients are on diabetes medications. We aim to have &gt;98% of active patients have documented HbA1c as well as documentation as to why they are not on medication if they HbA1c is over 6.5%. We will also look for all</td>
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<td>Milestone 12 [I-20]: Generate registry-based reports for each provider/care team for the care delivered outside the office visit, which may include historical and peer comparisons to help providers see how well they are managing their patients chronic health needs compared to other doctors in the hospital/clinic system. Metric: Increase or achieve number or reports sent out to a number or percent of primary care providers over the 12-month period. Baseline/Goal: Reports will be generated for over 75% providers/care teams for care delivered outside the office visit. Data Source: Returned reports</td>
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<td>Milestone 2</td>
<td>Estimated Incentive Payment: $457,650</td>
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<tr>
<td><strong>[P-2]</strong> Review current registry capability and assess future needs. <strong>Metric 1 [P-2.1]</strong> Documentation of review of current registry capability and assessment of future registry needs. <strong>Baseline/Goal:</strong> Current registry analyses reveal the need to improve documentation of lab tests and vital signs and in identifying the usual source of care. Our goal is to streamline and standardize documentation of key variables and source of care. <strong>Data Source:</strong> EHR systems and chart review. Report on data completeness for diabetes, hypertension, and HIV.</td>
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</table>

**Milestone 3**

**[P-3]** Develop cross-functional team to evaluate registry program. **Metric:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program.

**Milestone 6**

**[P-6]:** Conduct staff training on populating and using registry functions. **Metric:** Documentation of training programs and list of staff members trained, or other similar documentation. **Baseline/Goal:** By year 5, have all key staff in Brady Green clinics understand how to read and use the registry. **Data Source:** HR or training.

<table>
<thead>
<tr>
<th>Milestone 5</th>
<th>Estimated Incentive Payment: $502,557</th>
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<tbody>
<tr>
<td><strong>Data Source:</strong> Registry and reports on numbers of patients with data on outcome measures as well as values.</td>
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</table>

**Milestone 9**

**Estimated Incentive Payment: $716,825**

**Milestone 10**

**[I-15]:** Increase the percentage of patients recorded in the registry. **Metric 1 [I-15.1]:** 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. **Baseline/Goal:** Goal is to increase the percentage of patients with diabetes in the registry by 5%. Our goal is to do this with comments from providers; provider interviews.

**Milestone 12**

**Estimated Incentive Payment: $1,038,877**

**Milestone 13**

**[I-22]:** Increase the percentage of patients with chronic disease entered into registry who receive instructions appropriate for their chronic disease or MCCs, such as: activity level, diet, medication management, etc. **Metric:** Percentage of patients with chronic disease who receive appropriate disease specific discharge (or peer support) instructions. **Baseline/Goal:** A target for our initiative is reducing the not arrived rate. For patients with chronic pain on narcotics, our goal is to have 80% receive urine drug testing at least once a year. We will also monitor the morphine equivalent doses for these patients and offer feedback to 100 percent of the providers about the risks of doses over 50 per day. **Data Source:** disease registries as...
<table>
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<tr>
<th>Milestone 3 Estimated Incentive Payment:</th>
<th>$457,650</th>
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</thead>
<tbody>
<tr>
<td><strong>Milestone 4</strong> [P-4]: Implement/expand a functional disease management registry. <strong>Metric [P-4.1]</strong>: Registry functionality is currently available in none of the Performing Provider’s sites. Our goal includes an expanded number of targeted diseases or clinical conditions. <strong>Data source</strong>: We are just now starting to offer data to the practices about their diabetes and HIV patients and will be attempting to offer specific feedback to providers about their patients’ status. Documentation from 2 primary care practices and 1 HIV practice of availability of registry data for quality of care assessments and defining at risk patients.</td>
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<tr>
<td><strong>Milestone 5</strong> [P-4.2]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps by reducing non-attendance to scheduled visits and targeting persons who fail to meet treatment goals for support to keep scheduled care. We will also monitor use of inpatient and ED services as well as urgent care sites such as ExpressMed to insure that these patients receive extra support to reduce this urgent care utilization. <strong>Metric</strong>: Implement and document results of test plan. <strong>Data Source</strong>: Test plan.</td>
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<tr>
<td><strong>Milestone 6 Estimated Incentive Payment</strong>:</td>
<td>$502,557</td>
</tr>
<tr>
<td><strong>Milestone 7</strong> [P-7]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps by reducing non-attendance to scheduled visits and targeting persons who fail to meet treatment goals for support to keep scheduled care. We will also monitor use of inpatient and ED services as well as urgent care sites such as ExpressMed to insure that these patients receive extra support to reduce this urgent care utilization. <strong>Metric</strong>: Implement and document results of test plan. <strong>Data Source</strong>: Test plan.</td>
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<tr>
<td><strong>Milestone 7 Estimated Incentive Payment</strong>:</td>
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<tr>
<td><strong>Milestone 8</strong> [P-7.1]: Have a complete updated registries for patients with hypertension, long-term opioids (defined as at least 90 days in a 6 month period), and HIV infection. <strong>Data Source</strong>: Registry completeness for diabetes, hypertension, chronic pain and HIV as compared with chart review of a sample of patients and numbers from billing and the electronic medical record. Providers will be asked to review of questionable cases. <strong>Milestone 10 Estimated Incentive Payment</strong>:</td>
<td></td>
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<tr>
<td><strong>Milestone 9</strong> [P-7.2]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps by reducing non-attendance to scheduled visits and targeting persons who fail to meet treatment goals for support to keep scheduled care. We will also monitor use of inpatient and ED services as well as urgent care sites such as ExpressMed to insure that these patients receive extra support to reduce this urgent care utilization. <strong>Metric</strong>: Implement and document results of test plan. <strong>Data Source</strong>: Test plan.</td>
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<tr>
<td><strong>Milestone 10 Estimated Incentive Payment</strong>:</td>
<td>$716,825</td>
</tr>
<tr>
<td><strong>Milestone 11</strong> [I-17]: Use the registry to identify patients that would benefit from targeted patient education services. Specifically, we will target patients who keep less than 75% of their scheduled appointments and are not meeting their health goals. Develop and implement patient support programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-</td>
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<tr>
<td><strong>Milestone 12 Estimated Incentive Payment</strong>:</td>
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<tr>
<td><strong>Milestone 13</strong> [I-17.1]: Have a complete updated registries for patients with hypertension, long-term opioids (defined as at least 90 days in a 6 month period), and HIV infection. <strong>Data Source</strong>: Registry completeness for diabetes, hypertension, chronic pain and HIV as compared with chart review of a sample of patients and numbers from billing and the electronic medical record. Providers will be asked to review of questionable cases. <strong>Milestone 13 Estimated Incentive Payment</strong>: $1,038,877</td>
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</tr>
<tr>
<td><strong>Milestone 14</strong> [I-17.2]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps by reducing non-attendance to scheduled visits and targeting persons who fail to meet treatment goals for support to keep scheduled care. We will also monitor use of inpatient and ED services as well as urgent care sites such as ExpressMed to insure that these patients receive extra support to reduce this urgent care utilization. <strong>Metric</strong>: Implement and document results of test plan. <strong>Data Source</strong>: Test plan.</td>
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<tr>
<td><strong>Milestone 15 Estimated Incentive Payment</strong>:</td>
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<tr>
<td><strong>Milestone 16</strong> [I-17.3]: Have a complete updated registries for patients with hypertension, long-term opioids (defined as at least 90 days in a 6 month period), and HIV infection. <strong>Data Source</strong>: Registry completeness for diabetes, hypertension, chronic pain and HIV as compared with chart review of a sample of patients and numbers from billing and the electronic medical record. Providers will be asked to review of questionable cases. <strong>Milestone 16 Estimated Incentive Payment</strong>:</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 17</strong> [I-17.4]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps by reducing non-attendance to scheduled visits and targeting persons who fail to meet treatment goals for support to keep scheduled care. We will also monitor use of inpatient and ED services as well as urgent care sites such as ExpressMed to insure that these patients receive extra support to reduce this urgent care utilization. <strong>Metric</strong>: Implement and document results of test plan. <strong>Data Source</strong>: Test plan.</td>
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</tr>
<tr>
<td><strong>Milestone 18 Estimated Incentive Payment</strong>:</td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $ 457,650</td>
<td>$502,557 Milestone 8</td>
</tr>
</tbody>
</table>
at least 80% of targeted patients.

**Metric 3 [I-17.3]:** Establishment of training programs developed and conducted by clinicians.

**Data Source:** Internal clinic or hospital records/documentation.

**Baseline/Goal:** No providers have been trained in offering patient support materials for self-management of hypertension, diabetes, and weight control. Goal is to have reached 95% of the providers in the Brady Green Clinic with educational materials about the interventions and educate them about providing all patients with disease specific information to overcome barriers to achieving goals.

**Milestone 11 Estimated Incentive Payment:** $716,825

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $1,830,601</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,010,226</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,150,475</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,077,753</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $8,069,055</td>
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</tr>
</tbody>
</table>
## Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>1.2.3 Increase the number of residency/training program for faculty/staff to support an expanded, more updated program: Residency Expansion for Family Medicine Residency UTHSCSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>085144601.1.3 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>University of Texas Health Science Center at San Antonio - Mark T. Nadeau, MD</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>085144601</td>
</tr>
</tbody>
</table>

## Project Summary:

<table>
<thead>
<tr>
<th>Provider:</th>
<th>The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention(s):</td>
<td>Clearly state the intervention(s).Example: This project will increase the number of primary care physicians trained in San Antonio by increasing the size of the UTHSCSA Family Medicine Residency.</td>
</tr>
<tr>
<td>Need for the project:</td>
<td>Texas has a severe shortage of primary care physicians. Recruiting agencies are currently reporting that these positions are hard to recruit physicians into since there is a nationwide shortage. The best solution is to train more primary care physicians here is San Antonio since many residency graduates practice nearby to where they train.</td>
</tr>
<tr>
<td>Target population:</td>
<td>The Target population ultimately is all patients in South Texas since there is a general shortage of primary care. During training, residents will see an underserved, underinsured population of patients in San Antonio.</td>
</tr>
<tr>
<td>Category 1 or 2 expected patient benefits:</td>
<td>More graduates from the Family Medicine residency will mean more primary care physicians in South Texas. Most of our graduate practice in Texas, many stay in San Antonio.</td>
</tr>
<tr>
<td>Category 3 outcomes:</td>
<td>Right care in right setting and patient centeredness: 15 % increase of primary care visits in the FHC during years 4 and 5</td>
</tr>
<tr>
<td>Number of residents who remain in South Texas to practice after 2 years. Expected increase is 10%</td>
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</table>

## Project Description:

<table>
<thead>
<tr>
<th>Brief Description:</th>
<th>Increase the number of primary care physicians in South Texas by increasing the number of Family Medicine residents in training.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td>Increase residency from 12 residents per year to 13 residents per year.</td>
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<tr>
<td>Expected Outcome:</td>
<td>In year one, increase to 39 residents in training with 13 graduates per year with increases in number of faculty members and patient visits consistent with the growth.</td>
</tr>
<tr>
<td>Challenges/Issues:</td>
<td>The major challenge for this project is the funding. Currently, we have 38 funded positions. Two of three classes are on 4 week schedules. The other class rotates on a monthly schedule. All funded positions are filled, and faculty are maximally engages. Additional faculty support would be important.</td>
</tr>
</tbody>
</table>
A longer term vision would be to grow the program to 15 residents per year, then to 18 residents per year. The patient care base exists to develop the residency to this size. However, a project of that magnitude requires coordination, approval and support from many outside organization, including the ACGME, other university department and University Health System. More space is needed in the FHC and more CareLink patients and Medicaid Pediatric patients assigned to our practice. Several additional faculty members would be needed for the larger expansion, and it takes time to develop or hire faculty members. We would need 240 more deliveries per year to train the residents, which would require coordination and support from OB/Gyn. We likely would need the support of other departments to help us ensure that we have the right inpatient experiences for a quality residency. Other support needed from other departments should not be a major issue. By the 5 year point, the residency should be able to have 15 residents per year, with the possibility of being ready to recruit the first class of 18 residents at that time.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs. CMS does have a system to support graduate medical education nationwide which includes funding for resident salaries which is paid to the hospitals. There are no other federal funds involved in the project.

Starting Point/Baseline:

The residency practice sees over 30,000 visits per year. Increasing the resident complement will increase the amount of patient care provided in addition to increasing the amount of training. The number of patients that can be enrolled into the clinic as a Patient Centered Medical Home should increase consistent with the increase in number of visits. Increasing to 15 residents per year should increase the number of patient visits by 15,000 and the number of patients enrolled in the clinic as a Patient Centered Medical Home by 3000.

Rationale:

Texas has a growing shortage of primary care doctors due to increasing population and an aging Of the population. There is a decline in the number of medical students choosing primary care. Only a very small percentage of Internal Medicine and Pediatric residency graduates do primary care as the majority of their career. The most important number in determining the number of physicians doing primary care in the future is the number of Family Medicine residency training slots. Qualified applicants are available for an expanded number of positions.

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 give patients an opportunity to have
a personal physician and a Patient Centered Medical Home, which should improve quality and reduce costs. Expansion of Family Medicine residency slots will strengthen an integrated health care system and play a key role in implementing disease management programs.

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.

In 2010, Texas ranked 47 in the number of primary care patients per 100,000 population. Increasing medical school enrollment, as has occurred in Texas will have no effect on the problem since the number of residency positions in the state is inadequate in most specialties and especially inadequate in Family Medicine. The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry level GME positions for each Texas medical school graduate. To get to this number, 400 additional GME Positions are needed. The shortage of GME positions for primary care is the most important aspect of the state’s physician shortage.

CN.3 Addresses provider shortage needs
CN.2 By addressing provider shortages disparities in health outcomes will also be addressed

### Related Category 3 Outcome Measure(s):

- Appropriate Care, Appropriate Setting
- Reduced ED utilization
- By increasing the number of primary care physicians coming into the system from local training programs, patients in South Texas will have better access to primary care services in the Patient Centered Medical Home. There is ample evidence that services in this setting are more comprehensive and are delivered at lower cost. By improving access to primary care, fewer patients will need to rely on local Emergency Departments of on going care.

### Relationship to other Projects:

The project will support and reinforce the Advanced Primary Care, Enhance PCMH infrastructure project. We will work closely with that group to incorporate The training curriculum developed for the medical assistants will be directly relevant to that project as will lessons learned about implementing elements of the medical home.

### Relationship to Other Performing Providers’ Projects in the RHP:

### Plan for Learning Collaborative:

I am aware of some early discussions about creating a Family Medicine residency in McAllen at Doctors Hospital Renaissance. There is some hope that this can be associated with DSRIP. If this concept becomes a reality, there will be opportunities for collaboration on activities to grow the number of primary care physicians in South Texas.
<table>
<thead>
<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>The project is valued based upon achieving waiver goals, meeting community needs, increasing the scope of services available to the community, and resources deployed. Although the outcome domain chosen targets number of physicians in training, each additional trainee is expected to graduate from residency. Since 90% of physician practice near where they train, this should greatly increase the number of practicing primary care physicians in Texas, including Health Profession Shortage Areas. Improved availability of services can be expected to improve health outcomes for the communities of South Texas.</td>
</tr>
</tbody>
</table>
### Milestone 1
**[P-X] Match 1 additional resident (13 total)**
- **Start date for training:** July 2013
- **Metric 1 [P-X.1]:** 13 total residents hired for the class entering July of 2013
  - **Baseline/Goal:** 13 per year, eventually to grow to 15 per year
  - **Data Source:** Residency office files
- **Milestone 1 Estimated Incentive Payment:** $508,500

### Milestone 2
**[P-X]:** Hire one additional faculty member

### Milestone 3
**[P-X]:** Application for larger program to ACGME
- **Metric 1 [P-X.1]:**
  - **Baseline/Goal:** 13 per year, eventually to grow to 15 per year
  - **Data Source:** Residency office files
- **Milestone 4 Estimated Incentive Payment:** $558,396

### Milestone 4
**[P-X]:** Application for larger program to ACGME
- **Metric 1 [P-X.1]:**
  - **Baseline/Goal:** 13 per year, eventually to grow to 15 per year
  - **Data Source:** Residency office files
- **Milestone 5 Estimated Incentive Payment:** $896,031

### Milestone 5
**[I-X]:** 13 total residents hired for the class entering July of 2014
- **Metric 1 [I-X.1]:**
  - **Baseline/Goal:** Report number of residents interviewed and matched to the residency.
- **Milestone 6 Estimated Incentive Payment:** $1,731,463

### Milestone 6
**[P-X]:** Hire a second additional faculty member
- **Metric 1 [P-X.1]:** Report the number of additional faculty hired.
- **Data Source:** Personnel records

### Milestone 7
**[P-X]:** Hire a second additional faculty member
- **Metric 1 [P-X.1]:** Report the number of additional faculty hired.
- **Data Source:** Personnel records
- **Milestone 8 Estimated Incentive Payment:** $896,031

### Milestone 8
**[I-X]:** 15 total residents hired for the class entering July of 2015
- **Metric 1 [I-X.1]:** Report number of residents interviewed and matched to the residency.
- **Data Source:** NRMP Match

### Milestone 9
**[I-X]:** 15 total residents hired for the class entering July of 2016
- **Metric 1 [I-X.1]:** Report number of residents interviewed and matched to the residency.
- **Data Source:** NRMP Match
- **Milestone 9 Estimated Incentive Payment:** $1,731,463
<p>| Metric 1 [P-X.1] Report the number of additional faculty hired. | the residency. Data Source: Report the number of additional faculty hired. Milestone 5 Estimated Incentive Payment: $558,396 | the residency. Data Source: NRMP Match Estimated Incentive Milestone 8 Incentive Payment: $896,031 |
| Data Source: Personnel records | Milestone 2 Estimated Incentive Payment: $508,500 |  |
| <strong>Milestone 3</strong> [P-X] Undertake the necessary planning, redesign of education process to eventually increase the number of residents to 18 per year. Coordinate with University Health System for additional space needed if larger expansion is imminent. | <strong>Milestone 6</strong> [P-X]: ACGME site visit Metric 1[P-X.1] Report the results of internal review of the program and the scheduled date of ACMGE (RRC) site visit. Data Source: ACGME Correspondence and Program Information Form |  |
| <strong>Metric 1 [P-X.1] Gap assessment of workforce shortages Report projected rotation schedules for 45 residents.</strong> Data Source: Department Meeting minutes, ACGME correspondence, GMEC Meeting minutes, Program Information Form | Milestone 6 Estimated Incentive Payment: $558,396 |  |</p>
<table>
<thead>
<tr>
<th>Milestone 3 Estimated Incentive Payment: $508,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount:</td>
</tr>
<tr>
<td>$ 1,525,501</td>
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<tr>
<td>Year 3 Estimated Milestone Bundle Amount:</td>
</tr>
<tr>
<td>$ 1,675,189</td>
</tr>
<tr>
<td>Year 4 Estimated Milestone Bundle Amount:</td>
</tr>
<tr>
<td>$ 1,792,062</td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount:</td>
</tr>
<tr>
<td>$ 1,731,463</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 6,724,213**
**Identifying Project and Provider Information:**

| Title: 1.9.2 Improve access to specialty care: Implement EpicCareLink Referral Portal |
| Unique RHP ID#: 085144601.1.4 – PASS 1 |
| Performing Provider: University of Texas Health Science Center at San Antonio; Timothy D. Barker, MD |
| Performing Provider TPI: 085144601 |

**Project Summary:**

**Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** This project will make 90% of UT Medicine Specialty Clinics accessible through the EpicCareLink electronic referral system while significantly increasing the volume of specialty clinic visits at UT Medicine.

**Need for the project:** UT Medicine does not have a system in place to accept electronic referrals from non-UT Medicine physicians. DY2 will be used to develop baseline data for the number of specialty care clinic visits and patient satisfaction scores related to referral access issues.

**Target population:** UT Medicine provides care for over 205,000 unique patients per year. 17% are covered by Medicaid, 17% by Carelink (the local county indigent coverage program) and 5% are self-pay.

**Category 1 or 2 expected patient benefits:** The percentage of UT Medicine specialty clinics accepting referrals via EpicCareLink will be 10% in DY3, 50% in DY4 and 90% in DY5. The volume of care provided by UT Medicine specialty clinics will increase by 5% over baseline each year from DY3 through DY5. Assuming a baseline of 20,000 specialty care visits per year in DY2 the increase would result in 21,000 visits in DY3, 22,050 in DY4 and 23,152 in DY5.

**Category 3 outcomes:** In DY 2 the focus will be on project planning, establishing baseline patient satisfaction scores and developing and testing the EpicCareLink referral system. Once baseline satisfaction scores are available the outcome improvement target for DY 3-5 will be determined. DY 3 will be devoted to conducting Plan Do Study Act (PDSA) cycles, disseminating findings through learning collaboratives and beginning to demonstrate improvement in patient satisfaction scores. The focus in DY 4-5 will be continued improvement in patient satisfaction scores.

**Project Description:**

UT Medicine San Antonio is an academic medical practice which includes physicians from more than 60 different medical specialties and sub-specialties from the faculty of the School of Medicine at the University of Texas Health Science Center at San Antonio. As such, UT Medicine fills a critical role as a major provider of medical specialty care for South Texas. The current phone based system of referring patients to UT Medicine for specialty care is cumbersome, inefficient, and frustrating for primary care physicians and presents a significant barrier to specialty care for patients in need of those services. The process of communicating patient information from UT Medicine specialists back to referring physicians yields inconsistent
and often unsatisfactory results. This observation is consistent with the conclusion drawn in the 2010 Bexar County Health Assessment that care is often fragmented.

Patients needing specialty care are at high-risk of admissions and/or readmissions, and streamlining their access to specialty physicians can help manage their conditions and therefore avoid unnecessary ED utilization, hospitalizations or readmissions. The goal of this project is to make the specialty care services of UT Medicine more accessible to non-UT Medicine physicians throughout the South Texas area through the implementation of a web based, HIPAA compliant, referral portal integrated with UT Medicine’s EpicCare electronic health record (EHR) system. This portal will enable primary care physicians throughout South Texas to arrange for referrals online and subsequently access their patients’ health information in UT Medicine’s EHR system. In addition, UT Medicine will add marketing staff to promote the use of the referral portal and referral management staff to process electronic referrals.

The 5-year expected outcome of this project is to make 90% of UT Medicine Specialty Clinics accessible through the EpicCareLink electronic referral system while significantly increasing the volume of specialty clinic visits at UT Medicine.

Quality:
To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

**Starting Point/Baseline:**
UT Medicine does not have a system in place to accept electronic referrals from non-UT Medicine physicians. DY2 will be used to develop baseline data for the number of specialty care clinic visits and patient satisfaction scores related to referral access issues.

**Rationale:**
The overall goal of this project is to increase referrals from non-UT Medicine physicians throughout the South Texas area to specialty care services at UT Medicine. An increase in referrals will allow UT Medicine to further expand capacity to meet the need for specialty care throughout the RHP. Ultimately more patients will have access to specialty care and their wait times for specialty appointments will decrease. Improved communication between referring providers and UT Medicine specialists will result in improved care overall. In order to achieve these goals UT Medicine will implement a robust referral management system to ensure that referrals are processed, reviewed and the patient’s clinical issue addressed in a timely manner.

The community need addressed by this project is health information technology to improve physicians’ lines of communication and health care quality (RHP 6 Community Needs Assessment). The project option for this proposal is 1.9.2 – Improve access to specialty care with components c) Implement transparent, standardized referrals across the system. d)
Conduct quality improvement for the project in the form of Plan Do Study Act cycles focusing on identifying and addressing key challenges. Components a, and b are beyond the scope of this project.

We are unaware of any projects currently underway at UTHSCSA funded by the US Department of Health and Human Services serving a similar purpose as this project.

CN.1 This project meets the community need for enhanced quality of care.
CN.3 This project meets the community need for enhanced access to health care services.

### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Outcome Measure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-6 Patient Satisfaction</td>
</tr>
<tr>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores, item 3 patient’s rating of doctor access to specialist</td>
</tr>
</tbody>
</table>

The RHP 6 needs assessment has identified access to specialty care as a key health challenge for the region, and continued population growth is expected to exacerbate this problem in the future. A large academic medical center in the Midwestern US addressed a problem with specialty care access by implementing a web-based referral system, showing that referrals generated through that system were more than twice as likely to lead to a scheduled visit with a specialty physician (Weiner, M, El Hoyek, G. A web-based generalist-specialist system to improve scheduling of outpatient specialty consultations in an academic center. J Gen Intern Med. 2009 Jun;24(6):710-5).

We have selected the Category 3 outcome measure of **IT-6.1 Percent improvement over baseline of patient satisfaction scores, item 3 patient’s rating of doctor access to specialist** (Standalone measure). The baseline for this measure will be determined in year 2 using data obtained from supplemental modules for the adult CG-CAHPS survey.

### Relationship to other Projects:

This project is related conceptually to the proposal submitted by UTHSCSA – Implement a Shared Electronic Health Record (EHR) System. While this project opens a referral portal for physicians in the region, the shared EHR project would make the complete EHR available to unaffiliated physicians.

### Relationship to Other Performing Providers’ Projects in the RHP:

Given the nature of this project, there is either a direct or indirect relationship to all other projects in the region.

### Plan for Learning Collaborative:

University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives through the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following: identify participants, establish learning collaborative goals, develop a calendar of regular meetings, site visits, and/or conference calls, develop a plan to communicate ideas, data, and successes across the region and state, organize a learning event and invite experts and other performing providers from outside the region to share knowledge and best practices.
**Project Valuation:**

In 2010 Bexar county had 14,769 potentially preventable hospitalizations costing approximately $370,000,000 at $25,212 per hospitalization (www.dshs.state.tx.us/ph). Access to specialty care will reduce the number of potentially preventable hospitalizations as well as preventable emergency department visits. We anticipate that this project will prevent at least 80 hospitalizations over the project period resulting in a savings of $2,016,960.
<table>
<thead>
<tr>
<th>085144601.1.4 PASS 1</th>
<th>1.9.2</th>
<th>NA</th>
<th>1.9.2 Improve access to specialty care: IMPLEMENT EPICCareLink Referral Portal</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>University of Texas Health Science Center at San Antonio</th>
<th>TPI - 085144601</th>
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</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.5</td>
</tr>
<tr>
<td></td>
<td>3.IT-6.1</td>
</tr>
<tr>
<td></td>
<td>Percent improvement over baseline of patient satisfaction scores – patient’s rating of doctor access to specialist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-7]:</td>
<td><strong>Milestone 3</strong> [I-24]:</td>
<td><strong>Milestone 5</strong> [I-24]:</td>
<td><strong>Milestone 7</strong> [I-24]:</td>
</tr>
<tr>
<td>Complete a planning process/submit a plan to implement electronic referral technology.</td>
<td>Implement specialty care access program – EpicCareLink</td>
<td>Implement specialty care access program – EpicCareLink</td>
<td>Implement specialty care access program – EpicCareLink</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Development of a staffing plan for referral system.</td>
<td><strong>Metric 1</strong> [I-24.1]: Number of primary care and medical specialty clinics with specialty care access programs.</td>
<td><strong>Metric 1</strong> [I-24.1]: Number of primary care and medical specialty clinics with specialty care access programs.</td>
<td><strong>Metric 1</strong> [I-24.1]: Number of primary care and medical specialty clinics with specialty care access programs.</td>
</tr>
<tr>
<td>Goal: Staffing plan for referral system has been completed.</td>
<td>Numerator: Number of primary care and medical specialty clinics with specialty care access programs. Denominator: Total number of primary and medical specialty clinics</td>
<td>Numerator: Number of primary care and medical specialty clinics with specialty care access programs. Denominator: Total number of primary and medical specialty clinics</td>
<td>Numerator: Number of primary care and medical specialty clinics with specialty care access programs. Denominator: Total number of primary and medical specialty clinics</td>
</tr>
<tr>
<td>Data Source: Referral plan, describes the number and types and staff and their respective roles needed to implement the system.</td>
<td>Goal: 10% of UT Medicine clinics accepting referrals via EpicCareLink.</td>
<td>Goal: 50% of UT Medicine clinics accepting referrals via EpicCareLink.</td>
<td>Goal: 90% of UT Medicine clinics accepting referrals via EpicCareLink.</td>
</tr>
<tr>
<td>Metric 2 [P-7.2]: Development of an implementation plan for e-referral.</td>
<td>Data Source: Written workflows of referral management processes, documentation of specialty care access program, documentation of utilization of specialty care access</td>
<td>Data Source: Written workflows of referral management processes, documentation of specialty care access program, documentation of utilization of specialty care access</td>
<td>Data Source: Written workflows of referral management processes, documentation of specialty care access program, documentation of utilization of specialty care access</td>
</tr>
<tr>
<td>Goal: Referral plan completed.</td>
<td>Data Source: Referral plan, which describes the technical</td>
<td>Data Source: Referral plan, which describes the technical</td>
<td>Data Source: Referral plan, which describes the technical</td>
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</tbody>
</table>

**Milestone 2** [I-24]: Number of primary care and medical specialty clinics with specialty care access programs. Numerator: Number of primary care and medical specialty clinics with specialty care access programs. Denominator: Total number of primary and medical specialty clinics | Goal: 10% of UT Medicine clinics accepting referrals via EpicCareLink. | Goal: 50% of UT Medicine clinics accepting referrals via EpicCareLink. | Goal: 90% of UT Medicine clinics accepting referrals via EpicCareLink. |
<table>
<thead>
<tr>
<th>Milestone 1 Estimated Incentive Payment: $406,800</th>
<th>Milestone 3 Estimated Incentive Payment: $446,717</th>
<th>Milestone 5 Estimated Incentive Payment: $477,883</th>
<th>Milestone 7 Estimated Incentive Payment: $461,723</th>
</tr>
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<tbody>
<tr>
<td><strong>Milestone 2</strong> [I-23] Increase UT Medicine specialty care clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 [I-23.1]</strong>: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: will be established in DY2. Data Source: EHR</td>
<td><strong>Milestone 4</strong> [I-23] Increase UT Medicine specialty care clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 [I-23.1]</strong>: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5% increase over baseline. Assuming a baseline of 20,000 specialty care visits per year in DY2 the increase in DY3 would be 1000 to a total of 21,000. Data Source: EHR</td>
<td><strong>Milestone 6</strong> [I-23] Increase UT Medicine specialty care clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 [I-23.1]</strong>: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5% increase over DY3. Assuming a baseline of 20,000 specialty care visits per year in DY2 the number of visits would increase to 22,050 in DY4. Data Source: EHR</td>
<td><strong>Milestone 8</strong> [I-23] Increase UT Medicine specialty care clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 [I-23.1]</strong>: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5% increase over DY4. Assuming a baseline of 20,000 specialty care visits per year in DY2 the number of visits would increase to 23,152 in DY5. Data Source: EHR</td>
</tr>
<tr>
<td>Year</td>
<td>Estimated Milestone Bundle Amount</td>
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<td></td>
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<tr>
<td>Year 2</td>
<td>$813,600</td>
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<tr>
<td>Year 3</td>
<td>$893,434</td>
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<td>Year 4</td>
<td>$955,766</td>
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<tr>
<td>Year 5</td>
<td>$923,446</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $3,586,246
Project Summary:

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): This project will implement a Health Information Exchange (HIE) which will automate the flow of key clinical information between disparate EHR systems. Data in the HIE will be used to populate a chronic disease registry enabling effective population management.

Need for the project: UT Medicine and University Health System do not exchange health information in a meaningful way, and neither organization shares information with the local (HIE) - HASA. UT Medicine does not currently maintain a Chronic Disease Management Registry.

Target population: University Health System provides care to more than 230,000 unique patients every year. 19% are covered by Medicaid and 43% are self-pay. UT Medicine provides care for over 205,000 unique patients per year. 17% are covered by Medicaid, 17% by Carelink (the local county indigent coverage program) and 5% are self-pay. Many patients overlap between University Health System and UT Medicine.

Category 1 or 2 expected patient benefits: The Chronic Disease Management Registry Committee (CDMRC) will meet on at least a quarterly basis to evaluate registry functionality, guide enhancements to the data capture system, and expand the clinical use of the registry for identification and recall of targeted patients. The project seeks to add 1% of active patients to the registry in DY2, 5% by DY3, 10% by DY4 and 20% by DY5.

Category 3 outcomes: DY 2 will be devoted to project planning, developing and testing the chronic disease database/registry and establishing baseline rates of diabetic patients in the registry with HbA1C > 9.0%. In DY 3 we will begin to conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities, disseminate our findings to other groups and reduce the percentage of diabetic patients with HbA1C > 9.0% by 1% compared to the baseline that will be determined in DY 2. In DY 4 we will reduce the percentage of diabetic patients with HbA1C > 9.0% by another 1%. In DY 5 we will reduce the percentage of diabetic patients with HbA1C > 9.0% by another 1%, resulting in a reduction of 3% by the end of the waiver.

No other federal funds are utilized in this project.

Project Description:

UT Medicine and University Health System share thousands of patients and hundreds of medical
staff, yet have separate electronic health record (EHR) systems that do not currently exchange health information in a meaningful way, thus presenting many challenges for patient care, particularly with transitions of care. This project will address the lack of connectivity between UT Medicine, University Health System and the community Health Information Exchange (HIE) Healthcare Access San Antonio (HASA). This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Patient care is currently negatively impacted by the inaccessibility of the UT Medicine ambulatory EHR in the University Health System Emergency Department and Hospital. When a patient who receives specialty or primary care services at a UT Medicine clinic using the EpicCare EHR presents for care at the University Hospital Emergency Department the ED personnel do not have immediate access to information in EpicCare and therefore must rely on patient supplied data regarding past medical history, current medical problems, medications, allergies, diagnostic tests, etc. In this scenario the lack of access to key clinical information prolongs the patient’s stay in the ED, and may result in duplicated diagnostic tests or a preventable hospital admission. Patient safety could be placed at risk if the information supplied by the patient is incomplete or inaccurate. With a functional HIE the HIE client application within the ED’s EHR system would alert ED personnel to the availability of important clinical information from the ambulatory EHR and at the same time make that information immediately available. A 13 month study in Memphis, Tennessee found that accessing HIE data was associated with a decrease in hospital admissions and statistically significant decreases in head CT use, body CT use, and laboratory test ordering (Frisse ME, Johnson KB, Nian H. The financial impact of health information exchange on emergency department care. J Am Med Inform Assoc 2012 19: 328-333.).

The following scenario describes a patient admitted to University Hospital and discharged with a follow up appointment with their UT Medicine PCP or a UT Medicine Specialist. The results of several important diagnostic studies are pending at the time of discharge. The patient misses their hospital follow up appointment due to transportation issues that are beyond their control. Inadequate access to transportation services is a frequent barrier to seeking health care and accessing community resources among Bexar residents (2010 Bexar County Health Assessment. p. 224). The results of the diagnostic studies reveal a potentially serious new health problem, but these results never made their way through a cumbersome paper system to the patient’s UT Medicine PCP or Specialty Physician. With the HIE’s patient list management feature the PCP would have been alerted to the patient’s admission and discharge and they would receive the results of studies that become available after the patient’s discharge.

Next, consider how the currently fragmented medical record negatively impacts UT Medicine’s ability to optimally manage high risk patients such as a poorly controlled diabetic patient who has been recently discharged from the hospital. As UT Medicine transitions to the Patient Centered Medical Home (PCMH) model of care more emphasis is being placed on identifying, tracking, and performing outreach to high risk patients. The current manual system for tracking high risk patients recently discharged from the hospital is inefficient and ineffective. By
implementing a Chronic Disease Management Registry which automatically captures data from UT Medicine and University Health System, via their shared HIE, and other local hospitals and providers, via the community HIE, it will become possible to proactively manage recently discharged high risk patients in an efficient manner, ensuring that they return for important post discharge clinic visits and receive important support services so that they avoid unnecessary hospital readmissions.

Five year expected outcomes include:

- Glycemic control of patients with diabetes mellitus will improve.
- The Chronic Disease Management Registry Committee (CDMRC) will meet on at least a quarterly basis to evaluate registry functionality, guide enhancements to the data capture system, and expand the clinical use of the registry for identification and recall of targeted patients.
- The HIE will include data from at least 20 percent of active patients and, where applicable, data from those patients will be used to populate the Chronic Disease Management Registry.

Quality:
To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:
UT Medicine San Antonio is an academic medical practice including physicians from primary care and more than 60 different medical specialties and sub-specialties from the faculty of the School of Medicine at the University of Texas Health Science Center at San Antonio and provides access to critical services to residents of Bexar county and South Texas. UT Medicine operates 13 clinics in the San Antonio area. In addition, many UT Medicine physicians care for patients at University Health System clinics, and University Hospital. University Hospital, is a Bexar county owned 498 bed hospital, is one of just 15 Level I trauma centers in Texas, and the lead trauma center for all of South Texas. The Emergency Center at University Hospital is the busiest in the region and averages nearly 70,000 visits each year. In addition, University Health System provides a broad range of healthcare services at multiple clinic locations, including the Robert B. Green Campus, Texas Diabetes Institute, 13 neighborhood clinics across the community, five urgent-care clinics (ExpressMed) and four outpatient renal dialysis centers. Healthcare Access San Antonio (HASA) is a 501 (c)(3) community collaborative initiative to enhance access to health and medical care for Central Texas residents through health information exchange (HIE).

At baseline UT Medicine and University Health System do not exchange health information in a meaningful way, and neither organization shares information with HASA. UT medicine does not
currently maintain a Chronic Disease Management Registry

**Rationale:**  
San Antonio has a majority Hispanic population and Hispanic/Latino Americans are 2 times more likely to have diabetes than non-Hispanic whites. Diabetes is the 6th leading cause of death in Texas, the 4th leading cause of death in Bexar County and affects 11.8% of the population. The overall target goal of this project is the implementation of a state of the art Chronic Disease Management Registry built on the foundation of a new health information exchange (HIE) system. Chronic disease care is the specific issue and need noted in the Community Needs Assessment that this project will address.

Automating the flow of key clinical information between disparate EHR systems will vastly improve the safety, efficiency, and effectiveness of care transitions between University Health System and UT Medicine. According to the Roadmap to Better Care Transitions and Fewer Readmissions (US Department of Health and Human Services. http://www.healthcare.gov/compare/partnership-for-patients/safety/ transitions.html) “safe, effective and efficient care transitions should include…standardized and accurate communication and information exchange between the transferring and receiving provider in time to allow the receiving provider to effectively care for the patient.”

All of the following required core project components will be a part of this project.

- a) Enter patient data into unique chronic disease registry
- b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
- c) Use registry reports to develop and implement targeted QI plan
- d) Conduct quality improvement activities for the project using methods such as rapid cycle improvement. Activities may include: identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety net populations

We are unaware of any projects currently underway at UTHSCSA funded by the US Department of Health and Human Services serving a similar purpose as this project.

CN.2 The projects address community need CN.2 per the needs assessment.

**Related Category 3 Outcome Measure(s):**

We have chosen **IT 1.10 Diabetes care: HbA1c poor control (>9.0%) NQF 0059** as the Category 3 outcome measure for this project. Diabetes registries have been shown to be an effective tool to help manage underserved populations with diabetes as evidenced by improvements in A1C values (Seto W, Turner BS, Champagne MT, Liu L. Utilizing a diabetic registry to manage diabetes in a low-income Asian American population. Population Health Management 2012;15:220-229). Sixty percent of the 16,000 deaths in RHP 6 in 2008 were the result of preventable causes including diabetes. According to the RHP 6 Needs Assessment, “Disease management …programs are critical to reducing morbidity and mortality of these diseases.”
<table>
<thead>
<tr>
<th><strong>Relationship to other Projects:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This project directly relates to the proposal submitted by UTHSCSA - Install and Launch a Disease Management Registry. The db Motion HIE will populate the data warehouse described in this proposal. This project is also related to the proposal submitted by University Health System - Build a Registry for Chronic Diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relationship to Other Performing Providers’ Projects in the RHP:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Given the nature of this project, there is either a direct or indirect relationship to all other projects in the region.</td>
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<tr>
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<td>University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives through the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following: identify participants, establish learning collaborative goals, develop a calendar of regular meetings, site visits, and/or conference calls, develop a plan to communicate ideas, data, and successes across the region and state, organize a learning event and invite experts and other performing providers from outside the region to share knowledge and best practices.</td>
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<tr>
<th><strong>Project Valuation:</strong></th>
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<tbody>
<tr>
<td>In 2010 alone Bexar county had 14,769 potentially preventable hospitalizations costing approximately $372,000,000 at $25,212 per hospitalization (<a href="http://www.dshs.state.tx.us/ph">www.dshs.state.tx.us/ph</a>). Access to specialty care will reduce the number of potentially preventable hospitalizations as well as preventable emergency department visits. We conservatively anticipate that this project will prevent at least 500 hospitalizations over the four year project period resulting in a total savings of $12,606,000.</td>
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</tbody>
</table>
### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**  
[P-3] Develop cross-functional team to evaluate registry program  
**Metric 1**  
[P-3.1] Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program  
**Baseline/Goal:** Team will meet on a regular basis as the Chronic Disease Management Registry Committee (CDMRC) to evaluate and improve the registry program.  
**Data Source:** CDMRC Roster and meeting minutes  
**Milestone 1 Estimated Incentive Payment:** $1,017,001

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3**  
[P-6]: Conduct staff training on populating and using registry program  
**Metric 1**  
[P-6.1]: Documentation of training programs and list of staff members trained.  
**Baseline/Goal:** Training materials have been developed and 10 trainees have completed initial training.  
**Data Source:** Training program materials.  
**Milestone 3 Estimated Incentive Payment:** $1,116,793

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5**  
[P-8]: Create/disseminate protocols for registry driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with diabetes  
**Metric 1**  
[P-8.1]: Submitted protocols for the diabetes for A1C and LDL cholesterol  
**Baseline/Goal:** Protocols have been developed for A1C and LDL Cholesterol including goals and criteria for patient recall.  
**Data Source:** Protocols  
**Milestone 5 Estimated Incentive Payment:** $1,194,708

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 7**  
[P-9]: Implement an electronic process to correctly identify number of screening tests that require additional follow up  
**Metric 1**  
[P-9.1]: Documentation of an electronic process to correctly identify number of screening tests that require additional follow up  
**Baseline/Goal:** Identification of diabetic patients in need of screening for diabetic retinopathy.  
**Data Source:** Reporting documentation  
**Milestone 7 Estimated Incentive Payment:** $1,154,308
<table>
<thead>
<tr>
<th>Milestone 2</th>
<th>Milestone 4</th>
<th>Milestone 6</th>
<th>Milestone 8</th>
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<tbody>
<tr>
<td>[I-15] Increase the percentage of patients enrolled in the registry.</td>
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<td>Baseline/Goal: 1 percent of active patients (seen within 1 year) will be included in the HIE. Data Source: HIE database, EHR records</td>
<td>Goal: 5 percent of active patients (seen within 1 year) will be included in the HIE. Data Source: HIE database, EHR records</td>
<td>Goal: 10 percent of active patients (seen within 1 year) will be included in the HIE. Data Source: HIE database, EHR records</td>
<td>Goal: 20 percent of active patients (seen within 1 year) will be included in the HIE. Data Source: HIE database, EHR records</td>
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</table>

Milestone 2 Estimated Incentive Payment: $1,017,001

Milestone 4 Estimated Incentive Payment: $1,116,793

Milestone 6 Estimated Incentive Payment: $1,194,708

Milestone 8 Estimated Incentive Payment: $1,154,308

Year 2 Estimated Milestone Bundle Amount: $ 2,034,001

Year 3 Estimated Milestone Bundle Amount: $ 2,233,585

Year 4 Estimated Milestone Bundle Amount: $ 2,389,416

Year 5 Estimated Milestone Bundle Amount: $ 2,308,615

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 8,965,617
Identifying Project and Provider Information:
Title: 1.14.2 Other Project Option: Expand Specialty Care Capacity through the Sustained Treatment as an Outpatient Priority (STOP) Program
Unique RHP ID#: 085144601.1.6 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio-John Roache, Ph.D. and Pedro Delgado, M.D.
Performing Provider TPI: 085144601

Project Summary:

Provider Description:
The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): In collaboration with our regional healthcare partner, this project will establish the Sustained Treatment is an Outpatient Priority (STOP) Program as a means to provide a substance abuse disorder (SUD) training program within the Bexar County community setting. It will develop the infrastructure (Category 1, Project Area 1.14.2) to expand the capacity to provide evidence-based interventions for SUD in order to reduce the unnecessary use of hospital and emergency room services by patients in Bexar County. The intervention will increase access to specialty care providers of SUD treatment by 1) recruiting addiction specialists to structure and support the evidence-based treatment programs necessary for developing Psychology and an American Council on Graduate Medical Education (ACGME)-approved Addictions Psychiatry program; 2) providing the evidence-based treatment by psychiatrists, advanced practice nurses, psychologists and social work care providers utilizing evidenced-based medication prescription and motivational and cognitive behavioral therapy (CBT); and 3) providing advanced SUD treatment training for Psychiatry Residents and Fellows as well as Psychology Interns and Fellows, advanced practice nurse trainees, and social work students.

Need for the project: SUDs are highly prevalent conditions in Bexar County and there are an insufficient number of SUD treatment programs or community treatment providers; even less that use evidence-based approaches; and none that take the sustained treatment approach to prevent relapse. The STOP Program will implement two evidence-based initiatives to support increased access to innovative care in the underserved community. First, we plan a training program involving multidisciplinary teams including psychiatry, psychology, nursing, and social work. In this model, psychological therapies are considered essential, but for many patients, not sufficient approaches to care. Many patients also require medications and social work outpatient case management approaches to treatment – especially given the prevalence of dual diagnosis psychiatric needs in the population. The Transition Care Clinic (TCC) in the Dept. Psychiatry is successfully taking this approach to training multidisciplinary teams in the transitional care and outpatient stabilization of acutely ill community psychiatry patients. Not only are the training experiences of trainees improved by the
multidisciplinary environment, but also, patient care needs are more comprehensively met in a coordinated fashion by the multiple disciplines working together. Our second innovation is the deployment of multidimensional treatments in an outcomes-based approach. Most treatment clinics have a unitary treatment model (i.e., medication plus counseling, or 12-step group etc.) that all patients receive when they attend that clinic. However, research shows that only some 20-50% of patients entering treatment will demonstrate desirable outcomes and clearly, some patients are more likely to benefit with a particular approach (i.e., some benefit more than others with Cognitive therapies or some will do better in individual therapy than in group, etc.). This is the reason that evidence-based programs such as the Nexus Program in Dallas attempt to provide multiple different treatment options so that patients can access the continuum of care they most need at the time. The STOP program will add the innovation that current patient outcome will be monitored for individual patients so that patient care is individualized and maximized to match the individual patient needs.

**Target population:** Patients with SUDs in University Health System. The program will target recently hospitalized patients or those that are at high risk for hospitalization.

**Milestone Achievement benefits:**

**Yr02**, we expect to hire the necessary staff to conduct our preliminary Gap Analysis, hire and train a Licensed Practical Nurse to assure an initial launch of the STOP Program and begin seeing at least 100 patients; and to recruit an Addiction’s Psychiatrist; an Addiction’s Psychologist; and hire and train a Psychology Fellow and a Social Worker.

**Yr03**, we will have hired and credentialed all Faculty necessary to train at least 2 Psychiatry Residents, 2 Psychology Interns and 1 Fellow, 1 Nurse Practice student, and 1 Social Worker who will provide treatment for at least 800 patients.

**Yr04** The STOP program will expand by seeing more patients (at least 1200) and including more trainees at least 3 Psychiatry Residents, 2 Psychology Interns and 2 Fellows, 2 Nurse Practice students, and 2 Social Workers. We also expect to have established an ACGME accredited Addiction’s Fellowship and to begin recruiting Psychiatry Fellows though they may not be in place till later in the year.

**Yr05** will finally demonstrate the full potential of the STOP Program by training 4 Psychiatry Residents, and 2 Psychiatry Fellows, 3 Psychology Interns and 2 Psychology Fellows, 3 Nurse Practice students, and 3 Social Workers who will staff at least 1900 community patients.

The STOP Program will provide direct patient care for at least 4,000 SUD patients in a multidisciplinary environment where we will expand capacity by also training Psychiatry, Psychology, Social Work, and Nursing students outcomes-based programs to reduce hospitalization or rehospitalization. Though the program will take some time to build momentum, the recruitment of new faculty and growth in training programs are critically important steps to assure a growing and continued supply of community-based providers to address the overwhelming need of community SUD patients.

**Category 3 outcomes:** Our goal is to reduce potentially preventable admissions and readmissions to University Hospital. Preventable substance-related 30 day readmissions to the hospital will be reduced by at least 10%.
Project Description:

Substance Use Disorders (SUD), including alcoholism and drug dependence (including opiate, cocaine, and methamphetamine) are psychiatric conditions that are highly prevalent in Bexar County. The majority of people with an SUD also suffer from a chronic general medical condition or another psychiatric disorder and they contribute disproportionately to emergency room visits and complicated inpatient hospital admissions. Drug addiction may directly cause or exacerbate pulmonary, gastrointestinal, cardiovascular, hepatic, and infectious diseases that cost the county-area hospitals millions of dollars in health services each year. Further, people who are impaired due to use of an addictive substance have very high rates of trauma due to falls and motor vehicle accidents. For example, the annual number of deaths associated with accidental overdose or abuse of prescription opiates tripled in Bexar County between 2000 and 2010. The relatively small cost of treatment for alcohol or drug addiction results in multifold-increases in economic cost savings to the community in the form of reduced health care expense, reduced criminal justice expense, and increased economic productivity of rehabilitated patients. The scientific evidence-basis for treatment indicates that no one treatment works for all patients, but that effective outpatient intervention and long-term support (months to years) is necessary to affect long-term rehabilitation. Unfortunately, there are insufficient community provider resources to address the needs identified in the 2010 Community Health Assessment for Bexar County; Lifestyle Behaviors, Alcohol Consumption.

Therefore we propose to expand SUD specialty care capacity through infrastructure development (Category 1, Project Area 1.9.1) laying the foundation for delivery system transformation by increasing the number of providers of evidence-based interventions for SUD, in order to reduce the unnecessary use of hospital and emergency room services by patients in Bexar County. Currently, there are an insufficient range of evidence-based treatment options or integrated care programs in the community to help patients access the psychological and psychiatric continuum of care that many patients require or over the time-periods that are required. Through the establishment of a clinical training program for treatment of SUDs, this proposal will expand both the number of trainees that choose this area of training, the number of future providers for these services, and establish a program that supports access to specialty providers through a continuum of care of available treatment options. Finally, the program will enhance the continuity of patient care necessary to establish and sustain rehabilitation. UT Health Science Center will establish the Sustained Treatment as an Outpatient Priority (STOP) Program to support evidence-based clinical care and training opportunities for Psychiatry, Psychology, and Nursing Professionals in training. Through a collaboration with University Health System Primary Care Clinics, the STOP Program will expand the specialty care capacity in the area of SUDs and increase access to specialty care providers of SUD treatment by 1) recruiting addiction specialists to structure and support the evidence-based treatment programs necessary for developing an American Council on Graduate Medical Education (ACGME)-approved Addictions Psychiatry Fellowship program; 2) providing direct service to patients utilizing evidenced-based approaches; and 3) providing advanced SUD treatment training for Psychiatry Residents and Fellows, Psychology Interns and Fellows, and Advanced Practice Nurse trainees. All necessary
treatment planning and coordination, care provision, and training supervision will be achieved through the STOP program. Care will be provided within the context of a medical home model integrated into University Health System primary care clinics, providing for integration of behavioral healthcare into the medical environment. Consequently, the capacity, continuum, and continuity of outpatient care for SUD will be substantially increased. The STOP Program will enhance medication-treatment capacity and multimodal individual and group therapy options including cognitive behavioral therapy (CBT) which all have an evidence basis for outpatient detoxification, active intervention, relapse prevention, and long-term maintenance of rehabilitation. The multimodal treatment environment provides evidence-based mental health training in community primary care environments. It also expands the breadth and depth of services in University Health System and increases the continuum and continuity of care available to patients. The theoretical framework for the STOP Program is to provide Psychiatry, Psychology, and Psychiatric Advanced Practice Nurse Specialist training within an interdisciplinary evidence-based clinic providing psychiatric, psychological, and behavioral interventions at the acuity level necessary to achieve validated outcomes of success. Behavioral and motivational procedures will be used along with validated and standardized assessments to enhance training and program outcome. Urine drug screens will validate outcome, and medication cost subsidies will support evidence-based medication for patients without adequate financial means. The STOP Program will include a variety of medication and therapy approaches so that patients unsuccessfully-treated in one modality can switch to alternative care in a “patient-matching” approach that evidentially works for them. Finally, the STOP Program will support a rehabilitative maintenance clinic whereby psychiatric or relapse preventative medication can be maintained over time-periods of 6 months to 2 years after initial treatment and patients can return for supplemental therapy or booster therapy as necessary to prevent relapse. The STOP Program will consist of 2 Psychiatrists, 2 Advanced Practice Nurses, 1 Psychologist, and one Social worker as core faculty to provide direct patient care and supervision of a multidisciplinary group of up to 8 Psychiatry Residents and Fellows, Psychology Interns and Fellows, and Psychiatric Advanced Practice Nurse each year. The faculty alone will increase the capacity to provide SUD specialty care in our community, but the community provider base can be expected to grow with the addition of trainees graduating from our program with community programs expertise and interests in SUD specialty treatment.

The overall goal of the STOP Program is to increase the number of residents/trainees choosing the targeted shortage area of SUD treatment while increasing service availability by developing a novel program that will provide rapid access to a continuum of care options for SUD intervention. This program will: (a) benefit individuals by treating the underlying SUD-problems and allow them to remain productive members of the community; (b) benefit the RHP by directly reducing costs associated with ER visits and hospitalization, exacerbation of general medical illness, and reduce the need for other community services including emergency and medical services, as well as reduced law enforcement and jail expense. Program development will expand the breadth and depth of treatment services available in the community and will do so programmatically by design as well as through clinical provider resources from participating faculty and trainees. The outcomes-focused program using our continuum and continuity of care
model is expected to provide standardized and objectively-validated improvements in treatment outcome beyond what is available in any other outpatient treatment program in Bexar County. The long-term maintenance of relapse prevention provides a continuity of care that is not available in any other community program. Treatment success will improve the lives and health outcomes of STOP patients. It also will reduce the social, criminal-justice, and health-care expenditures of Bexar County because successful rehabilitation will reduce the unnecessary service utilization associated with comorbid disease deterioration or law enforcement and criminal incarceration.

Quality:

To achieve continuous quality improvement we shall assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

5-Year Project Goal.

Over the project period, the STOP program will increase the access to care for community patients with SUD by two important means. First, the STOP program will be staffed with Psychiatric and Psychology faculty training Fellows, Residents, and Interns in evidence-based community practice. Second, these clinical resources will provide a continuum and continuity of care that will provide treatment for an estimated 4,000 SUD patients. Two important outcomes will be achieved through this program. First, successful treatment and sustained relapse prevention will reduce readmission rates of UHS patients. Second, successful training will increase the number of community care providers in RHP 6 which will expand the access to evidence-based care beyond the STOP program.

Starting Point/Baseline:

No ACGME-approved addictions psychiatry fellowship programs are available in all of South Texas. Additionally, no evidence-based continuity of care model substance abuse treatment services are available in our community. Most existing programs lack the multimodal therapy and none include the medication-based dual diagnosis approach.

Rationale:

We selected Project Option 1.9.1 because the gaps generated by the lack of sufficient numbers of community providers or a continuum of evidence-based care programs in Bexar County are well known and documented already. Therefore, the STOP Program is designed to remedy the problem by increasing the number of SUD specialty care
providers and by establishing a clinical program that will provide a more complete continuum of evidence-based care (i.e., integrated medication and therapy) designed to reduce Relapse Risk.

We are not aware of any DHHS projects funded at UTHSCSA or in Bexar County to support this comprehensive approach to enhance substance abuse treatment in the community.

CN. 4 This project addresses the need for higher quality MH services that are better integrated with physical health care services.

**Related Category 3 Outcome Measure(s):**

We selected OD-3-IT-3.8 as a Category 3 Outcome because of the compelling cost-effectiveness argument where effective outpatient Specialty Care for SUD will result in reduced hospitalization or readmission through the STOP Program. Thus we expect to demonstrate potentially preventable readmissions of STOP Program patients once discharged from the hospital. Inadequate outpatient care for adults with moderate behavioral health needs including substance abuse/dependence is well known and was identified in the Section III Needs Assessment Report to result in unnecessary hospitalizations and Emergency Room visits. The STOP program will provide the outpatient continuum of care necessary to give University Health System primary care clinics with the referral source for patients to receive the level of substance abuse care required to prevent hospitalization and to provide inpatient and ER services with the outpatient follow-up necessary to prevent readmission. Successful rehabilitation and maintenance of relapse prevention through the STOP Program also will reduce unnecessary University Health System service utilization associated with comorbid disease deterioration.

**Relationship to other Projects:**

To our knowledge, no other programs within our institution are submitting applications to Develop specialty care capacity in the area of SUD’s. If such projects are identified, we’d be excited to work with them to coordinate programs and services and minimize overlap.

**Relationship to Other Performing Providers’ Projects in the RHP:**

There are other Performing Providers submitting applications within our department and institution, but none to our knowledge, developing workforce enhancement of SUD Specialty Care (Category 1.9.1) to treat substance abuse/dependence. If the RHP6 Anchor identifies other related projects submitted by Performing Providers from the community, we’d be excited to coordinate services or milestones and to learn from others experiences so as to minimize overlap while maximizing improvement outcomes for the RHP.
### Plan for Learning Collaborative:

There are other Performing Provider DSRIP projects being submitted that could help the RHP Anchor to achieve Category 3 Outcomes of preventable admissions. We have not as yet developed a Plan for a Learning Collaborative with this other applicants. However, we are open and ready to collaborate with others within the RHP6 to share challenges and new ideas for solutions to achieve similar improvements. As the RHP is a natural hub for such activity, we are ready to partner with the anchor and other Performing Providers to achieve our common goals. This can and should include regular meetings, site visits, and conference calls as planned by the RHP.

### Project Valuation:

The most important factor for valuation is the prevalence of substance abuse in the community with very few provider treatment options available. Any increase in the number of psychiatric or psychologically-based providers will be beneficial, but more important will be multidimensional continuum of care model of the STOP program which will provide unique enhancements to our community resources. We anticipate being able to treat more than 4,000 patients over the four year period of this project. Economic analysis suggests that community cost savings in medical and social costs approximate 3-7 times the cost savings of the expense of treatment. While there could be a wide range of parameters used to estimate the value of this program, if you consider only three factors, the anticipated value would be more than $6 million in cost savings. There are several ways to calculate this value: 1. Value to the individual patient. Of course productive employment is an important outcome of addictions treatment. A minimum wage employee would earn $15,600 in a year, which is a gain relative to unemployment costs to society of $14,400 for a net benefit of at least $30,000 per year per employed patient with only a minimum wage job. 2. Savings due to reduced ER Visits or Hospitalization. The costs of an ER visit would be $1,000-2,000 and the cost of University Health System of hospitalization ranges from $750-$2500 per day depending on the acuity of the visit. A 4-day length of stay for an alcohol detox may average $6,500 and treatment or triage preventing hospitalization would save University Health System that expense. Of course the costs of trauma care and transplant services and the treatment of infectious diseases are much higher and effective outpatient treatment will also reduce these adverse outcomes. 3. Cost associated with preventing a single fatality related to DWI is estimated to be $3,300,000. There also are substantial cost savings in law enforcement and incarceration costs that could be considered in terms of community savings.
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<tr>
<th>Milestone 1</th>
<th>Milestone 5</th>
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<tbody>
<tr>
<td>[ P-1]: Conduct specialty care gap assessment based on community need</td>
<td>[ P-1]: Conduct specialty care gap assessment based on community need (Quality Improvement Project)</td>
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<td>Metric 1 [P-1.1]: Documentation of gap assessment (baseline for DY2).</td>
<td>Metric 1 [P-1.1]: Demonstrate improvement in gap assessment over prior reporting period.</td>
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<tr>
<td>• Baseline analysis of the scope and breadth of community SUD programs and medical providers.</td>
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<td>• Baseline analysis of #’s of hospitalizations and ER visits at University Health System for SUD.</td>
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<td>Data Source: Hospital EMR data on admissions/visits and state licensure information on providers, and survey of provider programs.</td>
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<td>Milestone 2</td>
<td>Milestone 5 Estimated Incentive Payment: $502,557:</td>
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<td>[P-X] Expand SUD training</td>
<td>Metric P-X.1: Expand the SUD training in psychiatric residency, and mid-level providers (psychologists, physician assistants, nurse practitioners, and social work students).</td>
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<td></td>
<td>• Documentation of applications and agreements to expand training programs</td>
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<td>• Data Source: Training program documentation</td>
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<td></td>
<td>• Rationale/Evidence: Increasing TSC training may help improve access to targeted specialty services.</td>
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<td>Metric P-X.2: Establish precepting TSC faculty members</td>
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<td></td>
<td>• Hire Licensed Practical Nurse. Recruit , Psychology Post-Doc, and Addiction’s Psychiatrist, Psychologist, and Social</td>
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<td>Milestone 6</td>
<td>Milestone 9 Estimated Incentive Payment: $430,095</td>
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<td>• Documentation of recruitment of employment of Addiction’s Psychiatrist,</td>
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<td>Milestone 10</td>
<td>Milestone 15 Estimated Incentive</td>
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<td>• Data Source: HR documents, faculty lists</td>
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**Milestone 2**
Estimated Incentive Payment: $457,650

**Milestone 3**
[P-X2]: Launch a SUD treatment program (workforce enhancement initiative)

**Milestone 4**

**Milestone 5**

**Milestone 6**
Estimated Incentive Payment: $502,557

**Milestone 7**
[P-X2]: Launch a SUD treatment program (workforce enhancement initiative)

**Milestone 8**

**Milestone 9**

**Milestone 10**
Estimated Incentive Payment: $430,095

**Milestone 11**
[P-X2]: Launch a SUD treatment program (workforce enhancement initiative)

**Milestone 12**

**Milestone 13**

**Milestone 14**

**Milestone 15**

**Milestone 16**
Estimated Incentive Payment: $415,551

**Milestone 17**
[I-X]: Increase SUD training and/or rotations

Metric I-X.1: Increase the number of trainees getting SUD training, as measured by percent change of class
<table>
<thead>
<tr>
<th>Milestone 4</th>
<th>Milestone 7 Estimated Incentive Payment: $502,557</th>
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<tbody>
<tr>
<td>(Improvement Milestone) [ I-X]: Increase SUD training and/or rotations</td>
<td><strong>Metric I-X.1:</strong> Increase the number of trainees getting SUD training, as measured by percent change of class size over baseline and amount of training received (hours). Trainees will include physicians, mid-level providers (physician assistants and nurse practitioners), and/or other specialized clinicians/staff.</td>
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<tr>
<td><strong>Milestone 8</strong> [ I-31]: Increase SUD training and/or rotations</td>
<td>• Increase (above 0) in hours SUD training. Train 1 Fellow, and 1 social worker.</td>
</tr>
<tr>
<td><strong>Milestone 11 Estimated Incentive Payment: $430,095</strong></td>
<td>• Data Source: Documented enrollment by class by year SUD training program</td>
</tr>
<tr>
<td><strong>Milestone 12</strong> [ I-X]: Increase SUD training and/or rotations</td>
<td>• Rationale/Evidence: As the goal is to increase the SUD workforce to better meet the need for SUD treatment in the health care system by increasing training of the SUD workforce in Texas, the metric is a straightforward measurement of increased training.</td>
</tr>
<tr>
<td><strong>Metric I-X.1:</strong> Increase the number of trainees getting SUD training, as measured by percent change of class size over baseline and amount of training received (hours). Trainees will include physicians, mid-level providers (physician assistants and nurse practitioners), and/or other specialized clinicians/staff.</td>
<td><strong>Milestone 17 Estimated Incentive Payment:  $415,551</strong></td>
</tr>
<tr>
<td>• &gt;100 percent increase in hours SUD training. Train 2 Residents, 1 Fellow, 2 Interns, 1 social worker, and 1 nursing practice student</td>
<td><strong>Milestone 18</strong> [P-X3]: Maintain approval from the ACGME for Addictions Fellowship</td>
</tr>
<tr>
<td>• Data Source: Documented enrollment by class by year SUD training program</td>
<td><strong>Metric P-X3.1:</strong> ACGME approval for residency position expansion</td>
</tr>
<tr>
<td>• Rationale/Evidence: As the goal is to increase the SUD workforce to better meet the need for SUD treatment in the health care system by increasing training of the SUD workforce in Texas, the metric is a straightforward measurement of increased training.</td>
<td><strong>Milestone 18</strong> [P-X3]: Maintain approval from the ACGME for Addictions Fellowship</td>
</tr>
<tr>
<td><strong>Milestone 18</strong> [P-X3]: Maintain approval from the ACGME for Addictions Fellowship</td>
<td>Metric P-X3.1.: ACGME approval for residency position expansion</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $457,650</td>
<td>the need for SUD treatment in the health care system by increasing training of the SUD workforce in Texas, the metric is a straightforward measurement of increased training.</td>
</tr>
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</tr>
<tr>
<td><strong>Milestone 8 Estimated Incentive Payment: $502,557</strong></td>
<td><strong>Milestone 13</strong> [P-X3]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) for Addictions Fellowship</td>
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<tr>
<td><strong>Year 2 Estimated Milestone</strong></td>
<td><strong>Year 3 Estimated Milestone</strong></td>
</tr>
</tbody>
</table>

straightforward measurement of increased training.

- Number of fellowship slots
- Data Source: Documentation of ACGME approval for fellowship
- Rationale/Evidence: Increasing SUD training may help improve access to targeted specialty services.

Milestone 13 Estimated Incentive Payment: $430,095

- Number of fellowship slots
- Data Source: Documentation of ACGME approval for fellowship
- Rationale/Evidence: Increasing SUD training may help improve access to targeted specialty services.

Milestone 18 Estimated Incentive Payment: $415,551
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<tr>
<th>Bundle Amount: $1,830,601</th>
<th>Bundle Amount: $2,010,226</th>
<th>Bundle Amount: $2,150,475</th>
<th>Amount: $2,077,753</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,069,055**
### Identifying Project and Provider Information:

| Title: 1.9.2 Improve Access to Specialty Care: Outpatient Neurology Services |
| Unique RHP ID#: 085144601.1.7 – PASS 1 |
| Performing Provider: University of Texas Health Science Center at San Antonio-Michael Palm, MD |
| Performing Provider TPI: 085144601 |

### Project Summary:

**Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** This proposal is to improve access to outpatient neurology services with the addition of 1.0 FTE mid-level provider and 1.0 FTE LVN.

**Need for the project:** UTHSCSA Neurology provides care for the adult uninsured patients of Bexar County at University Health System’s downtown clinic. This clinic consists of a single general adult neurologist who provides clinic services 5 days per week. Approximately 150 patient visits are provided each month. The first available appointment is 3 to 4 months out with approximately 800 patients (as of Sept 2012) waiting to be seen. Timely access to outpatient neurology services for patients seen in the Emergency Department and discharged from the hospital will reduce inpatient length of stay and inappropriate admissions.

**Target population:**

The target population includes indigent, Medicare, and Medicaid patients referred by primary care providers for evaluation and/or management of neurological conditions and follow-up of patients seen in the Emergency Department or discharged from various hospital services. Greater than 90 percent of the neurology patients seen in this location are Medicaid/indigent.

**Category 1 or 2 expected patient benefits:**

This project seeks to increase the number of patients served to:

- **DY3:** 30 pct above baseline (195 visits per month)
- **DY4:** 40 pct above baseline (210 visits per month)
- **DY5:** 50 pct above baseline (225 visits per month)

**Category 3 outcomes:**

**IT-6.1 Patient Satisfaction Scores**

The goal is to improve patient satisfaction scores by 10 pct over baseline by DY5 as measured by the CG-CAHPS instrument for the following domains:

1. Timely care, appointments, and information
2. Patient rating of doctor access to specialist
**Project Description:**

**Background:**

The UTHSCSA Department of Neurology provides care for the adult uninsured patients of Bexar County through a contract with the Community Medical Associates. Services are provided through University Health System’s downtown clinic. The service consists of a single general adult neurologist who provides clinic services 5 days a week. In addition to seeing indigent, Medicaid and Medicare outpatients, this service is also tasked with provided timely follow-up visits for patients seen in Emergency Department as well as patients discharged from various hospital services, in an effort to provide continuity of care and prevent hospital readmissions. Some patients are evaluated and returned to their PCP, while others require ongoing neurologic workup or care. This service has been in place for 2 years, and it has had some success; however, the number of referrals has increased, so that the backlog of new referrals has markedly increased (see baseline data below). In addition, all available follow-up slots are being filled as well, so that the first available slot is typically 3-4 months out. Because of this, patient access is again becoming limited. In addition, the absence of consistent staffing has limited patient access via telephone.

**Goals:**

In order to provide continued high quality neurologic care to the indigent patients of Bexar County, accessibility needs to be increased. This proposal will increase accessibility by hiring 1.0 FTE mid-level provider to see follow up patients and 1.0 LVN to provide patients with improved telephone access and to perform injections and other procedures as required. We will utilize the skills of these providers and the neurologist in a team-based approach to improve the efficiency of neurologic care in this setting.

**Expected Result:**

With a mid-level provider seeing follow-up patients, access for follow-up patients is expected to improve. This will also allow additional time for the neurologist to see new patients, improving access to care. In addition with a nurse providing improved communication with patients, patient questions and concerns can be addresses more efficiently without the need for an additional visit with the neurologist.

The five-year expected outcome for this project is that the appointment capacity will be increased by 50 percent.

**Quality:**

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Region 6 goals:**
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:
Outpatient neurology services for the adult uninsured patients of Bexar County are provided through the University Hospital – Downtown Neurology Clinic consisting of a single adult neurologist who provides clinic services 5 days a week. In addition to seeing indigent, Medicare, and Medicare patients, this service is also tasked with providing timely follow up visits for patients seen in the Emergency Department as well as patients discharged from various hospital services in an effort to provide continuity of care, reduce length of stay, and prevent hospital readmissions. The number of referrals to the clinic is far in excess of the capacity resulting in a backlog of new referrals that has reached approximately 800 patients (as of 9/12). In addition, the first available follow up appointment slot is 3 to 4 months out.

Rationale:
Providing patients with increased access to neurologic services leading to earlier intervention in patients with neurologic illnesses may prevent or slow deterioration or improve quality of life, and decrease the need for emergency department visits. Currently, the clinic is not adequately staffed to meet the ongoing needs of patients with neurologic diseases. Lack of timely access to a neurologist results in unnecessary visits to the emergency department often resulting in unnecessary admissions and/or increased length of stay for services that are not available in a timely fashion.

We are unaware of any projects underway at UTHSCSA funded by the US Department of Health and Human Services serving a similar purpose as the project being submitted.

CN.1 Meets community need to improve quality and patient satisfaction

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores as measured by the adult CG-CAHPS instrument for the following domains: Timely care, appointments, and information; and patient rating of doctor access to specialist

Currently, more than 800 patients are waiting to be seen by the Neurology Clinic for an initial evaluation with follow-up appointments being scheduled more than 4 months from the date of the initial appointment.

The above measure was selected to measure patient satisfaction with access to services.

Relationship to other Projects:
UTHSCSA submitted a proposal to expand neuropsychological services. Individuals with neurological diseases and impairments require neuropsychological testing to effectively characterize neurocognitive changes associated with their diseases. Neuropsychological testing aids in patient management, diagnostic clarification, prediction of disease progression,
evaluation of disease staging, assessment of function status, and development of treatment recommendations.

### Relationship to Other Performing Providers’ Projects in the RHP:
This project will require the diagnostic services provided by the following proposal:

UTHSCSA 1.9.2 Neuropsychological Services

Providers from both proposals will collaborate to discuss best practices and treatment options for patients they both serve.

### Plan for Learning Collaborative:
This project is staffed by providers who will be faculty of the UTHSCSA Department of Neurology. As such, providers will participate in Departmental educational activities and discussions regarding best practices and treatment innovations which can be applied to the patient population served.

### Project Valuation:
Lack of timely access to a neurologist results in unnecessary visits to the emergency department often resulting in unnecessary admissions and/or increased length of stay for services that are not available in a timely fashion. Increased availability of outpatient neurologic services will result in reduced appointment waiting times, decreased ED utilization, and reduced lengths of stay.

The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
### 1.9.2 Improve Access to Specialty Care: Outpatient Neurology Services

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>085144601.3.8</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores for domains: 1) timely care, appointments, and information; and 2) patient rating of doctor access to specialist</th>
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<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
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<td>Milestone 1 Estimated Incentive Payment: $169,500</td>
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<tr>
<td>P-3 Collect baseline data for wait times, backlog, and/or return appointments in Neurology</td>
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<tr>
<td>Metric 1 [P-3.1]: Baseline/Goal: TBD; projected 150 visits per month</td>
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<tr>
<td>Appointment wait time</td>
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<td>Clinic visit volume</td>
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<td>Data Source: EPIC/Sunrise</td>
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<tr>
<td><strong>Milestone 4</strong></td>
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<td>Milestone 4 Estimated Incentive Payment: $558,396</td>
</tr>
<tr>
<td>I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
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<tr>
<td>Metric 1 [I-23.1]: Baseline/Goal: Increase capacity of patients served to 30 percent above baseline in year 2 (195 visits per month);</td>
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<td>Data Source: EPIC</td>
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<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
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<tr>
<td><strong>Milestone 5</strong></td>
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<td>Milestone 5 Estimated Incentive Payment: $597,354</td>
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<tr>
<td>I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</td>
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<tr>
<td>Metric 1 [I-23.1]: Goal: Increase capacity of patients served to 40 percent above baseline in year 2 (210 visits per month);</td>
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<td>Data Source: EPIC</td>
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<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Milestone 6</strong></td>
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<td>Milestone 6 Estimated Incentive Payment: $577,154</td>
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<tr>
<td>I-23: Increase specialty care clinic volume of visits and improved access for patients seeking service</td>
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<tr>
<td>Metric 1 [I-23.1]: Goal: Increase capacity of patients served to 50 percent above baseline in year 2 (225 visits per month);</td>
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<tr>
<td>Data Source: EPIC</td>
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<tr>
<td>Metric 1</td>
<td>Baseline/Goal: Number of specialist providers and qualified support staff over baseline (1.0 PA/NP, 1.0 LVN) Data Source: HR documents</td>
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<tr>
<td>Milestone 2 Estimated Incentive Payment: $169,500</td>
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</table>

**Milestone 3**

- P-11 Launch/expand a specialty care clinic
- Metric 1 Baseline/Goal: Number of patients served by specialty clinic Data Source: EPIC/Sunrise
- Milestone 3 Estimated Incentive Payment: $169,500

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $508,500</th>
<th>Year 3 Estimated Milestone Bundle Amount: $ 558,396</th>
<th>Year 4 Estimated Milestone Bundle Amount: $ 597,354</th>
<th>Year 5 Estimated Milestone Bundle Amount: $ 577,154</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,241,404**
Identifying Project and Provider Information:
Title: 1.9.2 Improve Access to Specialty Care: Neuropsychological Services
Unique RHP ID# : 085144601.1.8 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio-Russell Pella, PhD
Performing Provider TPI: 085144601

Project Summary:
Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): This proposal is to develop and expand the Neuropsychological Division to improve access to neuropsychological evaluation and testing services for patients with epilepsy, stroke, Alzheimer’s disease, brain tumors, and traumatic brain injuries with the addition of 1.0 FTE neuropsychologist and 1.0 FTE psychometrist.

Need for the project: The University has multiple programs and clinical services serving patients with neurological diseases and impairment but lacks adequate capacity to support the neuropsychological needs of these patients. Neuropsychological evaluation and testing provides effective characterization of neurocognitive changes and/or impairments associated with neurological diseases which aids in patient management, diagnostic clarification, prediction of disease progression, evaluation of disease staging, assessment of functional status and consequences of neurocognitive dysfunction, and the development of treatment recommendations. There is currently a six month wait to see the neuropsychologist for evaluation and testing.

Target population: Patients with epilepsy, stroke, Alzheimer’s disease, memory disorders, movement disorders, neuromuscular disorders, brain tumors, and traumatic brain injuries. Approximately 40 percent of the patients served will be Medicaid/indigent.

Category 1 or 2 expected patient benefits:
This project seeks to increase the number of patients served over the number served in baseline in DY2 (200 projected) to:

DY3: 25 pct above baseline (250 visits)
DY4: 50 pct above baseline (300 visits)
DY4: 100 pct above baseline (400 visits)

Category 3 outcomes:
IT-6.1 Patient Satisfaction Scores
The goal is to improve patient satisfaction scores in DY5 by 10 percent over baseline in DY2 for the following domains:

(1) Timely care, appointments, and information
(2) Patient rating of doctor access to specialist

The five-year expected outcome for this project is that an additional 350 patient visits for neuropsychological evaluation and testing will be provided.

**Project Description:**

The University of Texas Health Science Center at San Antonio serves a diverse population that lacks access to comprehensive personalized healthcare for individuals who are diagnosed with medical conditions affecting brain functioning. Such conditions often result in neuropsychiatric symptoms and impaired cognitive abilities both of which are risk factor for decline in functional abilities.

To address the behavioral health and medical needs of Bexar County and the San Antonio metropolitan population area, the Department of Neurology is proposing to develop and expand Neuropsychology Division that will improve access to neuropsychological testing services for patients with epilepsy, stroke, Alzheimer’s disease, brain tumors, and traumatic brain injuries with the addition of 1.0 FTE psychometrist and 1.0 FTE neuropsychologist.

**Region 6 Goals:**

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

**Quality:**

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Starting Point/Baseline:**

The Department of Neurology currently has 1.0 FTE faculty neuropsychologist who provided neuropsychological testing to 86 patients during the period November 2011 and June 2012.

**Rationale:**

The University has multiple neuroscience programs and clinical services in a number of departments serving patients with neurological diseases and impairments but does not have adequate capacity to support the neuropsychological needs of these patient populations. Effective characterization of neurocognitive changes and or impairments associated with neurological diseases aids in patient management, diagnostic clarification, prediction of disease progression, evaluation of disease staging, assessment of functional status and consequences of neurocognitive dysfunction, and development of treatment recommendations.

We are unaware of any projects currently underway UTHSCSA that are funded by the US Department of Health and Human Services serving a similar purpose as the project being submitted.
CN.3 This project expands access to care addressing provider shortages
CN.1 This project will enhance quality and improve patient satisfaction

Related Category 3 Outcome Measure(s):

IT-6.1 Percent improvement over baseline of patient satisfaction scores

There is limited access to neuropsychological testing services in Bexar County for patients with epilepsy, stroke, Alzheimer’s disease, brain tumors, and traumatic brain injuries.

The above measures were selected to measure patient access and demand for services as well as patient satisfaction with services.

Relationship to other Projects:

UTHSCSA submitted a proposal to develop a program to provide epilepsy care for outlying areas of South Texas. Individuals utilizing such a service will also benefit from neuropsychological services provided through the current proposal, which will expand the quality of care for patients in rural sectors of the region. There are also a number of clinical specialties within the sponsoring institution that are projected to benefit from neuropsychological services including movement disorder specialists, comprehensive epilepsy center, trauma center, stroke center, geriatric medicine, neurorehabilitation center, sports medicine, neurosurgery, psychiatry, and primary care.

Relationship to Other Performing Providers’ Projects in the RHP:

This project provides diagnostic services that are related to the following proposals:

- UTHSCSA 1.9 Expand Specialty Care Capacity: Epilepsy Outreach – Uvalde and
- UTHSCSA 1.9 Neurology Outpatient Services.

Plan for Learning Collaborative:

The South Texas Comprehensive Epilepsy Center based at University Health System consists of a multidisciplinary group of physicians and staff. This group meets weekly to review cases, exchange ideas, and discuss best practices/approaches to patient management. Services provided under this proposal will be included in these weekly discussions.

Project Valuation:

Individuals with medical conditions affecting brain functioning often result in neuropsychiatric symptoms impaired cognitive abilities. Both of which are risk factor for decline in functional abilities. A decline in functional abilities affects patients’ ability to obtain/maintain employment resulting in lost productivity and work-related earnings.
<table>
<thead>
<tr>
<th>085144601.1.8 PASS 1</th>
<th>1.9.2</th>
<th>N/A</th>
<th>1.9.2 Improve Access to Specialty Care: Neuropsychological Services</th>
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<tr>
<td>UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO</td>
<td>TPI - 085144601</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.10</td>
<td>3.IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
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</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1**
P-3 Collect baseline data for wait times, backlog, and/or return appointments in Neuropsychology

**Metric 1** P-3.1 Establish baseline for appointment wait time and clinic visit volume (200 projected)
Baseline/Goal: Collect data on current appointment wait time and clinic visit volume
Data Source: EPIC

**Milestone 2**
I-22 Increase the number of specialist providers, clinic hours and/or procedure hours

**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 3**
I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service

**Metric 1** [I-23.1]: Baseline/Goal: Increase capacity of patients served to 25 percent above baseline (250 patients);
Data Source: EPIC

**Milestone 3 Estimated Incentive Payment:** $223,358.50

**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 4**
I-22 Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties

**Milestone 5**
I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service

**Metric 1** [I-23.1]: Goal: Increase capacity of patients served to 50 percent above baseline (300 patients);
Data Source: EPIC

**Milestone 5 Estimated Incentive Payment:** $477,883

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 6**
I-23: Increase specialty care clinic volume of visits and improved access for patients seeking service

**Metric 1** [I-23.1]: Goal: Increase capacity of patients served to 100 percent above baseline (400 patients);
Data Source: EPIC

**Milestone 6 Estimated Incentive Payment:** $461,723
available for the high impact/most impacted medical specialties

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<tr>
<th>Metric 1</th>
<th>Milestone 2 Estimated Incentive Payment: $203,400</th>
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<tbody>
<tr>
<td>Baseline/Goal: Number of specialist providers and qualified support staff over baseline; hire 1.0 FTE psych technician</td>
<td>Data Source: HR documents</td>
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</table>

| Year 2 Estimated Milestone Bundle Amount: $406,800 | Year 3 Estimated Milestone Bundle Amount: $446,717 | Year 4 Estimated Milestone Bundle Amount: $477,883 | Year 5 Estimated Milestone Bundle Amount: $461,723 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,793,123
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<thead>
<tr>
<th>Identifying Project and Provider Information:</th>
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<tr>
<td><strong>Title:</strong> 1.1.2 Expand existing primary care capacity – Establish more primary care clinics</td>
</tr>
<tr>
<td><strong>Unique RHP ID#:</strong> 085144601.1.9 – PASS 1</td>
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<tr>
<td><strong>Performing Provider:</strong> University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Dr. Julie Cowan Novak</td>
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<td><strong>Performing Provider TPI:</strong> 085144601</td>
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<tr>
<th>Project Summary:</th>
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<tr>
<td><strong>Provider Description:</strong></td>
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<tr>
<td>The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.</td>
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<tr>
<th>Intervention(s):</th>
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<tr>
<td>The UT Nursing Clinical Enterprise provides care in four clinical settings (UTHSCSA Student Health Center, Employee Health and Wellness Clinic, community-based clinics: AVANCE Head Start and Healy-Murphy Alternative High School and Daycare. Care is provided to a population of approximately 10,163. Patient volume will increase to approximately 20,000 by year 4. This project will expand the hours and days of operation and primary care and psych/behavioral health services. Three of the four clinics are designated as Medically Underserved Populations (MUPs). The fourth clinic’s population is 60% from underrepresented groups.</td>
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<th>Need for the project:</th>
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<tr>
<td>This project will allow each clinic to expand its patient base to include care across the lifespan. Additional nurse practitioners are needed to integrate behavioral/mental health into primary care. This project will allow each clinic to expand its hours of operation and services to better serve their respective communities. Interprofessional students need clinical rotations and diverse community service learning sites. These settings provide rich learning laboratories for interprofessional Health Science Center students (Nursing, Medicine, PA, Dentistry, PT, OT and audiology).</td>
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<tr>
<th>Target population:</th>
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<tbody>
<tr>
<td>These patients need increased access to improved care that is cost effective. This project integrates psych/behavioral health into primary care. 50% of the students at Healy-Murphy are pregnant or parenting and approximately 50% of births in Bexar County are funded by Medicaid. The AVANCE and Healy-Murphy patient base includes approximately 4,000 patients who are eligible for Medicaid or are indigent. The patient base of these clinics will expand by 50% - 60% over the course of this project.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 1 or 2 expected patient benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patients will have the benefit of extended clinic hours (evenings) and days at AVANCE and Healy-Murphy from 2 days to 5 days/week. Patient populations will be expanded at each site (pediatric, adult and geriatric; across the lifespan). Services will be developed to include psych/behavioral health care, increased Harvard Brazelton Touchpoints parent coaching and patient educational programs regarding monthly evidence-based health promotion programs: (Healthy Eating and Activity Together (HEAT); ALA smoking cessation; Keep your children/yourself Safe, Secure (KySS) mental health promotion; Teen Outreach Program (TOP), teen pregnancy and dropout prevention) and chronic disease...</td>
</tr>
</tbody>
</table>
management. The benefit to the patients is increased access, additional days/extended hours of service; additional psych NP, hearing and pediatric screenings and services. This promotes a greater level of health promotion, disease prevention, early intervention, and patient/parent coaching which all contribute to ER diversion and lower cost care. Patient population and visits will increase as follows:

Year 2 encounters/patient visits will increase in Year 3 to: AVANCE 399 to 432; SHC 3006 to 3300; EHWC 1700 to 2040; Healy-Murphy 200 day care users only to 923 day care and high school users;

Year 3-4 will increase from: AVANCE 432 to 1200; SHC 3300 to 4030; EHWC 2040 to 2448, Healy-Murphy 1846 3 days per week;

Year 4-5 will increase from: AVANCE 1200 to 1920; SHC 4030 to 5872; EHWC 2448 to 2938; Healy-Murphy 1846 three days per week to 5533 five days per week (birth through elder patient population)

Category 3 outcomes: This project will increase collaborative interprofessional student and faculty participation by 50%-75%. It will allow increased admission of pediatric, family and psych/mental health NP students, hiring of primary care providers, allowing increased access to high quality, cost-effective health care. Pediatric patient appointments will increase by 40%; psych/behavioral health appointments will increase by 80% at the Student Health Clinic, AVANCE and Healy-Murphy sites and by 20% at the Employee Health and Wellness Clinic. Data analytics from the EPIC EHR system will promote care continuity, patient safety and quality, and will enable reporting to be shared with the community partners, UT peer groups, and disseminated at local, state and national nursing and interprofessional health and health policy conferences. The components noted in the project summary are reflected in the milestones. We are not aware of any similar projects at UTHSCSA funded by the USDHHS.

Project Description:

This project proposal, Nurse-Managed Clinics: Improving Access, Expanding Clinical Sites, Promoting Interprofessional Education and Evidence-based Practice, Optimizing EHR Use and Financial Sustainability, documents needs and addresses health problems identified within the “Bexar County Community Health Assessment.” This proposal meets the RHP 6 Community Needs Assessment and emphasizes primary care, health promotion and disease prevention, increases access to care, proposes integration of mental health services into primary care, promotes interprofessional practice and education, and promotes ER diversion through increased access, early intervention and patient/parent coaching/education at four sites. The UT Nursing Clinical Enterprise (UTNC) model serves a birth to 5 year old population (90% Latino) at the AVANCE Community Partnership Clinic (ACPC), an Early Head Start and Head Start site. The UTNC will expand service provision to the families of these infants and children as well as increase slots available for primary care nurse practitioner students as well as other Health Science Center students (Med, dentistry, PT, OT, PA and audiology). The second site, the UTHSCSA Student Health Center (SHC) will expand interprofessional healthcare for students’ family members. The SHC is a designated Medically Underserved Population (MUP) as more than 50% of students come from underrepresented groups and qualify for state and federal programs. Many report that they are Head Start graduates. Services would also be expanded at the third site, UTHSCSA’s Employee Health and Wellness Clinic where 60% of the population is from underrepresented groups. The fourth site, Healy-Murphy (a community partnership
The UTHSCSA clinic (78% Latino) will significantly expand and provide services within an alternative high school and day care center with a focus on health promotion/disease prevention. Expansion of this child and family centered Health Home model will provide full UTNC service across the lifespan. Community workers and senior public health nursing students will enhance care continuity through home visits. The four existing nurse-managed clinics target children and young adults, birth through college age, as well as the adult populations of employees, and parents and grandparents of the community-based clinics’ pediatric patients. This project is also consistent with the UTHSCSA, School of Nursing and School of Medicine strategic initiatives for healthcare: expand primary care services tailored to the needs of our patients; effective coordination and integration of care; enhance quality and delivery of care; develop alternative reimbursement methodologies that reward quality outcomes and efficiencies; explore novel opportunities for healthcare delivery. The number of patients served will exceed 20,000 annually with annual encounters increasing by 40-50%. Expansion of access to primary care is demonstrated in the number of patients we can care for during the project timeline in settings where the patients live, work, study or enroll in Head Start or daycare. Patient populations will expand as shown in the chart in the next section. This project targets health promotion/disease prevention, mental health, obesity, teen pregnancy, child abuse prevention, tobacco use prevention/cessation, and chronic disease prevention, intervention and management. Use of evidence-based interventions: NAPNAP CDC-approved KySS Mental Health promotion and Healthy Eating and Activity Together (HEAT); Harvard Brazelton Touchpoints parent coaching and child abuse prevention; Harvard/UVA Teen Outreach Program for teen and pregnancy and dropout prevention. The American Cancer Society evidence-based smoking cessation programs targeted to specific populations. This project has a high level of return on investment. One example is that the 50% of the teens at Healy-Murphy are pregnant or parenting - our services are helping them stay in school, graduate, and transition to a post secondary educational or training program. The parent coaching prevents child abuse. Our education, coaching, role modeling, and provision of healthcare aids in breaking the cycle - 70-80% of prisoners were abused as children and 80% were high school dropouts. Other programs for targeted audiences include tobacco use prevention/cessation using ACA developmental and age appropriate EB programs. Children who live with smokers have 4-16 times higher rates of Otitis Media than children who live with non-smokers. In addition, otitis media alone exceeds $6 billion in healthcare costs. Due to obesity, Type 2 diabetes is reaching epidemic proportions. The CDC-approved NAPNAP Healthy Eating Activity Together (HEAT) provides effective evidence-based prevention and intervention related to physical activity and eating disorders including obesity. These evidence-based programs are integrated into the School of Nursing Curriculum. Our community partnerships are well established and will allow us to achieve and sustain our milestones and metrics. One aspect of our mosaic of support and sustainability is the broad interprofessional participation. These evidence-based best practice programs are embedded in the School of Nursing curriculum. All interprofessional students will have access to computer modules for review.

Region 6 objectives:

This project achieves CMS’s **Triple Aim** objectives of assuring patients receive high quality and
patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Quality:

To achieve continuous quality improvement we shall assess the project’s impact and make adjustments as necessary, share best practices and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>AVANCE</th>
<th>SHC</th>
<th>EHWC</th>
<th>Healy-Murphy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base year 12/13</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters</td>
<td>450</td>
<td>7475</td>
<td>2478</td>
<td>200 @ ½ day/day care only</td>
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<tr>
<td>Users</td>
<td>399</td>
<td>3813</td>
<td>6000</td>
<td>150 High School; 200 day care</td>
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<td><strong>Year Two 13/14</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters</td>
<td>512</td>
<td>5210</td>
<td>2974</td>
<td>923 day care &amp; High School</td>
</tr>
<tr>
<td>Users</td>
<td>432</td>
<td>4318</td>
<td>6000</td>
<td>350 day care, high school, family members; care across life span</td>
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<tr>
<td><strong>Year Three 14/15</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters (High School)</td>
<td>1200</td>
<td>9823</td>
<td>3866</td>
<td>4218 - 3 days/week day care and</td>
</tr>
<tr>
<td>Users</td>
<td>1059</td>
<td>4818</td>
<td>7800</td>
<td>2112 - day care, high school, care across life span</td>
</tr>
<tr>
<td><strong>Year Four 15/16</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters</td>
<td>1920</td>
<td>11,982</td>
<td>5142</td>
<td>6684 5 days/week</td>
</tr>
<tr>
<td>Users</td>
<td>1200</td>
<td>5872</td>
<td>9360</td>
<td>3323 – day care, High School, family members; care across life span</td>
</tr>
</tbody>
</table>
**Rationale:**

The target goal of this project addresses the following RHP 6 community needs: Demographics, Healthcare provider shortage and Access to Primary Care; Health Provider Shortage for Mental Health; Chronic Disease; and Maternal Health:

The purpose of this proposal is to expand the four UT Nursing Clinic (UTNC) components of the UT Nursing Clinical Enterprise (UTNCE) to become interprofessional clinical sites and to increase access to primary health care. The expansion includes: strengthening the innovative and comprehensive nature of primary care delivered in the existing sites by integrating mental health services, significantly expanding the hours of clinic operation, thus increasing the number of medically underserved and vulnerable population constituents served without regard to insurance or ability to pay. **This will double the number of training slots for primary care practitioner, medical, dentistry, PT, OT, PA and audiology students.** An interoperable electronic health record (EPIC) system has been implemented across the sites for practice management, data collection/analytics related to safety and quality measures and improvement, patient and clinic outcomes, best practice guidelines, and expanding care across the lifespan in all sites. The result is a foundation for our enhanced model ultimately leading to a network of UTNCs in San Antonio and South Texas which is interprofessional and sustainable.

Not only does this project address one of the key aims of the Texas 1115 Waiver, this project is a perfect fit with the **Triple Aim** goals of assuring patients receive high quality and patient-centered care in the most cost-effective way – specifically primary care, mental health promotion, child abuse prevention, obesity prevention/intervention, and tobacco use prevention/cessation. One innovative aspect of the enhanced UTNC emerges from recognition that individuals with behavioral health problems present first in primary care settings with these settings being ill-equipped to meet urgent needs of these patients. The comprehensive primary care provided through the UTNC includes the integration of mental health services within the context of providing holistic interprofessional patient care. This addresses the issue of the RHP 6 counties being identified as a HPSA for mental health. Another novelty of this proposal is the diverse target population of both medically underserved and vulnerable populations who currently seek care at the UTNCs.

**In addition, our programs directly correlate to Table 5 of the RHP 6 Community Health Improvement Plan for Bexar County:** Priority Area – Healthy Eating and Active Living; UTNCE program – NAPNAP and CDC approved “Healthy Eating Activity Together” (HEAT); Priority Area – Healthy Child and Family Development; UTNCE program – NAPNAP and CDC approved “Keep Your Children/Yourself Safe and Secure” (KySS) and “Teen Outreach Program” (TOP – teen pregnancy and dropout prevention); Priority Area – Safe Communities; UTNCE program – “Touch Points” an evidence-based theory of child development, based upon more than 60 years of ground-breaking research by Dr. T. Berry Brazelton and his colleagues at Harvard Children’s Hospital in Boston and in communities around the world. The Touch Points program promotes healthy parenting thus breaking the cycle of child abuse. The KySS program promotes mental health, and the prevention of family dysfunction, violence, substance abuse, eating disorders, depression and suicide. 70-80% of prisoners were abused as children and 80% were high school dropouts.
This project addresses the need for greater access to primary care services in South Texas.

1.1.2 Expand existing primary care capacity
Required core project components:
  a) Expand primary care clinic space
  b) Expand primary care clinic hours
  c) Expand primary care clinic staffing

Related Category 3 Outcome Measure(s):
Project Area 1.1; OD- 9 Right Care, Right Setting; IT-9.2 ED appropriate utilization (Standalone measure)

Reduce ED visits for patients with asthma in the UTNCs Medicaid, pediatric and indigent populations. This project will allow accessible, cost-effective primary care, provide patient/parent coaching and education, and will allow maintenance of asthma care patients.

Relationship to other Projects:
1.7 - Introduce, Expand, or Enhance Telemedicine/Telehealth – Dr. Robert Novak
1.1 - Improving Inter-professional Team-Based Care for Patient Safety - Dr. Kathleen R. Stevens

Dr. Kathleen Steven’s TeamSTEPPS master’s trainers will complete a “train the trainers” with 30 UT Nursing clinic faculty, staff and interprofessional students from all four sites to further promote quality, safety and evidence-based practice.

Hearing health promotion and assessment are important components of primary healthcare from the EPSDT/Texas Team Steps for the Early Head Start/Head Start and daycare populations to the Student Health, Employee Health/Occupational Health to comprehensive care across the lifespan. Dr. Robert Novak’s project will promote hearing health promotion and the hearing assessment skills and skills related to innovative collaborative support of teleaudiology services with partner audiologists, for our faculty, staff and interprofessional students (2nd pass project).

Relationship to Other Performing Providers’ Projects in the RHP:
1.7 - Introduce, Expand, or Enhance Telemedicine/Telehealth – Dr. Robert Novak (2nd pass project)
1.1 - Improving Inter-professional Team-Based Care for Patient Safety - Dr. Kathleen R. Stevens

Plan for Learning Collaborative:
We look forward to participating in a RHP-wide learning collaborative. It is very important to share challenges and to learn from others. This will aid in sustaining each performing provider’s project and its success. We are available for any format selected, i.e., conference calls, meetings.
Project Valuation:

Objectives of the project will address such issues as the inability of the practitioner to communicate with the patient due to a language barrier, issues surrounding health literacy, and the inability of the patient to fully understand prescribed care. The majority of UTNC APNs are native Spanish speakers or bilingual. Developing and implementing systems and services: Our established clinics have systems and services in place; however, funding limitations result in clinic service provision only 1-2 days per week at AVANCE and Healy-Murphy. This project will allow primary and behavioral health care expansion at each site. Of the 3,813 Health Science Center students (Nursing, Medicine, Dentistry, Health Professions, and Basic Sciences), 50% come from underrepresented groups (38% Hispanic, 10% African American, and 2% “Other”) and qualify for state and federal programs. In FY2011, the SHC had 4,730 patient visits and averaged 20 patient visits a day. Thus far in 2012, patient visits have increased in the range of 40-50 visits per day. Services provided at the SHC and EHWC include health promotion/disease prevention, immunizations, comprehensive health assessments, diagnosis and management of acute and chronic health problems including behavioral health counseling, onsite collection of laboratory specimens, and ER diversion through early intervention and patient/parent coaching/education. All SHC and EHWC nurse practitioners (NPs) hold dual roles as faculty in the School of Nursing with cross appointments in the Department of Family Medicine. With the goal of expanding services at the SHC to dependents (children and spouses) of UTHSCSA students, we can increase primary care rotations for APN, PA and med students and service learning projects for students in other HSC programs, e.g., PT/OT. Inter professional students will participate in annual UTHSCSA employee health fairs, fun run/walks, pandemic preparedness, and research opportunities. The EHWC, serves approximately 6,000 UTHSCSA employees. The EHWC opened on November 15, 2010 and the patient base continues to grow. 60% of the employee population is from underrepresented groups. Redesigning and expanding the number of exam rooms in the SHC and EHWC, will allow a collaborative workspace for the interprofessional faculty and students of both clinics. In addition, this expansion would allow a private exam room for the counseling/behavioral health appointments and an evening pediatric clinic for children of HSC students and children enrolled at Murphy or AVANCE. In 2012, an employee survey by the HR department identified mental health issues as the top concern among UTHSCSA employees. A doctorally prepared psych mental health NP/APN will be added to each clinic.

The UTHSCSA AVANCE Community Partnership Clinic, is located within the very heart of the high-risk community it serves (a designated MUA). AVANCE has been a family/community program in SA for 40 years and is a national model. Two rooms have been dedicated to the clinic. With this funding, a third examination room will be fully equipped. AVANCE services 400 children from birth to age 3 and over 2,000 children city-wide with further expansion planned. AVANCE is ranked number 10 by the Hispanic Business Journal, as a significant contributor to parent education, promotion of parent’s high school completion and primary healthcare. This clinic is seen as a replicable model for the development of Head Start Health Homes. Since its inception, the clinic has ensured 100% immunization compliance among the enrolled children. The requested funding would allow expansion of services from 1.5 to 5 days a week. Women’s health services will be added. There is a documented need for services for the parents/grandparents, given an AVANCE Early Head Start 2011 survey where 29% of the parents reported alcohol or substance abuse disorders, 27% report domestic violence,
and 10% being on probation or parole. **Thirty-four percent reported mental health problems, with 18% reporting personal experience with child abuse and neglect.**

The Healy-Murphy Wellness Center (HMWC), is committed to serving at-risk youth, **including pregnant teens**, parents (both male and female), those who have dropped out of high school and others unable to achieve success in traditional school settings. HMWC is licensed by the state of Texas, and was one of only 17 schools in SA to receive the award for Texas School Readiness 2007-2011. Implementing the “TOP” program – Teen Outreach Program and education for teen pregnancy and dropout prevention is critical. **Also, having an on-site child development center and nurse-led clinic has provided young parents with a safe, nurturing educational environment for their children during the school day. This also allows APNs to provide care to the children on site, as most face transportation issues.** The high school serves approximately 150 students per year; approximately **50% of the students are pregnant, parenting, or both.** The culturally diverse population is 78% Hispanic, 18% African American, and 4% Anglo. Over 95% of students qualify for free or reduced meals. The daycare serves 200 infants/children per year, from 4 weeks to 5 years of age. The program is affiliated with the SA Independent School District.

A NAPNAP and CDC approved study entitled “KySS: Keep Your Children/Yourself Safe and Secure” revealed that approximately 1 in 4 children and teens experience mental health problems or psychosocial morbidities. A survey of 621 children/teens, and 603 of their parents reported concerns or “worries” regarding coping with stress, anxiety, depression, self-esteem problems and family relationships (Melnyk et al, 2001). Health care providers (600 PNPs and physicians) in the study contended that they were ill equipped to provide optimal care for children with these psychosocial morbidities. Increased educational content and continued education courses related to family dysfunction, substance abuse, eating disorders, depression and suicide were recommended and subsequently integrated into the UTHSCSA APN/Nurse Practitioner curriculum. Modules will be available for each of the interprofessional students to review the CB programs used in this project.

Since childhood obesity rates are alarming at 34% among Hispanics, the NAPNAP and CDC approved "Healthy Eating and Activity Together" (HEAT) evidenced based program will be introduced at each of the project sites. UTNCE provides parenting/childbirth classes, parent coaching using Harvard Touchpoints, behavioral/mental health promotion using evidence-based NAPNAP KySS and obesity prevention using evidence-based NAPNAP HEAT. Both the alternative high school students/parents and their children who attend the day care center are enrolled in Medicaid or meeting the criteria for enrollment. **The proposed project would significantly expand clinic operations from 1 day per week to 5 days per week.** Healy-Murphy received a capital improvement grant to create a 2,000 square foot clinic that opened August, 2012. This allows expansion of services and space for an interprofessional team of APN/NP students, PA students, and med students and their faculty. **This project will create a patient and family centered primary care health home for enrolled children expanding to include their parents and their grandparents and other family members over the course of the project years.** This interprofessional primary care Health Home and collaboration will allow integration of discovery, learning, and engagement. The content will be shared with all interprofessional student and faculty project participants. These clinics when expanded from one to five days/week can be operated for approximately 30-50% of the cost of traditional models.
<table>
<thead>
<tr>
<th>085144601.1.9</th>
<th>1.1.2</th>
<th>1.1.2 (A, B, C)</th>
<th>1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY-ESTABLISH MORE PRIMARY CARE CLINICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS 1</td>
<td></td>
<td></td>
<td>University of Texas Health Science Center at San</td>
</tr>
</tbody>
</table>

| TPI - 08514460 |  |  |  |

| Related Category 3 | Outcome Measure(s): |  | ED Appropriate Utilization |
|-------------------|---------------------|-----------------------------|
| 085144601.3.11    | IT-9.2              |                             |

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1**

[P-1]: Establish additional/expand existing/relocate primary care clinics

**Metric 1** [P-1.1]: [Expand space]
- Document the expansion plan with UTHSCSA Facility Services Dept. and determine short and long-term needs.

Data Source: Scope of Work and Architecture plan for expansion.

Milestone 1 Estimated Incentive payment: $339,000

**Milestone 2**

[P-2]: Implement/expand a community/school-based clinics program

**Milestone 3**

[P-1]: Establish additional/expand existing/relocate primary care clinics

**Metric 1** [P-1.1]: [Expand space]
- Initiate and complete Phase I of expansion to increase number of exam rooms from 3 to 4 for the EHCW; provide NP and interprofessional faculty and student team office for SHC/EHWC.

Data Source: Scope of Work and Architecture plan for expansion.

Milestone 4 Estimated Incentive Payment $372,264

**Milestone 4**

[P-1]: Establish additional/expand existing/relocate primary care clinics

**Metric 1** [P-1.1]: [Expand space]
- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1: [I-12.1] Patient visits will increase as follows:
- AVANCE 399 to 432
- SHC 3006 to 3300
- EHCW 1700 to 2040
- Healy-Murphy 200 day care users only to 923 day care and high school users

Milestone 7 Estimated Incentive Payment $298,677

**Milestone 5**

[P-2]: Implement/expand a community/school-based clinics program

**Milestone 6**

[P-2]: Implement/expand a community/school-based clinics program

**Milestone 7**

[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-12.1]: Patient visits will increase as follows:
- AVANCE 432 to 1200
- SHC 3300 to 4030
- EHCW 2040 to 2448
- Healy-Murphy 1846 3 days per week

Milestone 11 Estimated Incentive Payment: $577,153

**Milestone 8**

[P-2]: Implement/expand a community/school-based clinics program
<table>
<thead>
<tr>
<th>Metric 1 [P-2.1]: Number of additional hours. Expand hours of operation provided at two community clinics (AVANCE and Healy-Murphy). Expand from 8 to 16 hrs in each clinic (20%-40%).</th>
<th>clinics program Metric 1 [P-2.1]: Number of additional hours clinic Expand from 16 to 24 hours in each clinic. Increase psych care to 8-16 hours/week. Increase number of hours at SHC and EHWC by 8 hours week over DY 2. Add 4 hours of Psych/Mental Health NP to SHC and EHWC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Clinic Documentation, Epic reporting and data analytics</td>
<td>Data Source: Clinic Documentation, Epic reporting and data analytics</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $339,000</td>
<td>Milestone 3 [P-5]: [Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers] Metric 1 [P-5.1]: [Expand number of providers] Add Psych/Mental Health NP for SHC and EHWC at 10%. Hire 1 Nutritionist to treat patients/train students.</td>
</tr>
</tbody>
</table>
| Milestone 5 Estimated Incentive Payment $372,264 | Milestone 6 [P-5]: [Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers] Metric 1 [P-5.1]: [Documentation of increased number of providers and staff/clinic sites.]
Increase 1 part-time RN case manager to full time. Add 1 |
| Milestone 8 Estimated Incentive Payment: $298,677 | Milestone 9 [P-2]: [Implement/expand a community/school-based clinics program] Metric 1 [P-2.1]: [expanded hours] Expand MA and NP from 24 to 32 hrs in each clinic. Increase psych care to 24-32 hours/week. Increase number of hours at SHC by 16 hrs/week. Psych/Mental Health NP to SHC by 4 hours over previous |
| Milestone 12 Estimated Incentive Payment $577,153 | Metric 1 [P-2.1]: expanded hours Expand from 32 to 40 hours at each at each clinic. Increase Pediatric NP hours an additional to 40%.
Data Source: Clinic Documentation, Epic reporting and data analytics |
| Incentive Payment $339,000 | additional RN case manager. Increase nutritionist to 16 hrs/40%. Inter-professional students: 10 PNP; 10 FNP; 10 Senior Public Health Nursing; 10 Medical; 10 PA; 2 psych/MH NPs  
Data Source: HR Records, Clinic Documentation, Epic reporting, data analytics and student journals  
Milestone 6 Estimated Incentive Payment $372,264 | year,  
Data Source: Clinic documentation, Epic reporting and data analytics  
Milestone 9 Estimated Incentive Payment $298,677  
**Milestone 10**  
[P-5]: [Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers]  
Metric 1 [P-5.1]: [Documentation of increased number of providers and staff/clinic sites.)]  
Increase nutritionist to 24 hours. Inter-professional students: Add 2 inter-professional audiology students.  
Data Source: Clinic Documentation, Epic reporting, data analytics and student journals  
Milestone 10 Estimated Incentive Payment $298,677 |
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<td>5</td>
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<td>$1,154,307</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 4,482,808
Identifying Project and Provider Information:

Title: 1.1.1 Establish more primary care clinics: Primary care and behavioral care capacity expansion at UT Medicine San Antonio
Unique RHP ID#: 085144601.1.11 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio (UTHSCSA)
   Carlos R. Jaén MD, PhD
Performing Provider TPI: 085144601

Project Summary:

Provider Description:

The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): This project will build two new medical homes that in addition to the usual primary care clinicians, we will have services provided by behavioral health professionals, pharmacists, nutritionists and RN case management services to deal with patients with complex medical problems.

Need for the project: There are significant gaps in the number of primary care clinicians who practice in the region and thus lacks the capacity to care for common chronic diseases (e.g., diabetes and heart disease), provide clinical preventive services (e.g., colon cancer screening and breast cancer screening), and in the treatment of obesity and tobacco use disorder. Treatment of behavioral problems is also a big gap identified in the needs assessment. These gaps are effectively addressed by primary care and behavioral services that are integrated and community responsive. Moreover, building clinics such as the ones proposed here will help attract and retain more primary care clinicians to the region.

Target population: The target population is patients without primary care and behavioral health services, specifically Medicaid and indigent patients.

Category 1 or 2 expected patient benefits: By the end of this project, the region will have 10 additional primary care and behavioral health clinicians practicing in the community. The primary care capacity of UT Medicine will be increased by 25% to almost 50,000 unduplicated patients in all primary care clinics from a baseline of 39,818. At the end of the project we expect to be caring for a panel of 9600 patients. At this rate the value in savings to the system could be as high as $867,072 at the final year in savings to the region. By the 5th year, the clinics will have 4 FTE primary care physicians and 4 FTE PAs/NPs, 1 FTE behavioral clinician, 4 FTE RN care managers, 1 FTE dietician and 1 FTE primary care pharmacist. These two new clinics directly address the regional goal of expanding primary care capacity to serve residents of Bexar County, the largest county in the region, and by recruiting and retaining a primary care force needed to address critical chronic disease and prevention needs specifically among Medicaid and indigent patients.
Patient Benefit:

DY 3 4,000 unique patients clinic 1
DY4 12,600 visits clinic 1, and 1,000 visits clinic 2
DY5 12,720 visits clinic 1, and 12,000 visits clinic 2

Category 3 outcomes:

We selected IT 1.11 Diabetes care: BP control (<140/90mm Hg) NQF 0061 (Standalone measure) as our Category 3 outcome measure. Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes. The known prevalence of diabetes in Bexar County is 10% and more than double for African Americans (14%) and Hispanics (13%) compared to 6% among Non-Hispanic Whites. Hispanics represent 54% of residents of RHP 6. A highly functional primary care office in addition to increasing access will improve the quality of care for diabetics and hypertensives.

**Project Description:**

The overall goal is to increase UT Medicine San Antonio primary care capacity by 1/3 improving care for chronic diseases and prevention and also to enhance behavioral health availability by providing behavioral health services at the 2 new clinic locations. Considerable evidence is now accumulating that carefully executed transformation to a patient-centered medical home model achieves better outcomes with lower costs. In order to be effective medical homes must have staff and resources not usually available in primary care practices in most communities. We propose building new medical homes that in additional to the usual primary care clinicians, will have services by behavioral health professionals, pharmacists, nutritionists and RN case management services to deal with patients with complex medical problems. By the 5th year, the clinics will have 4 FTE primary care physicians and 4 FTE PAs/NPs, 1 FTE behavioral clinician, 4 FTE RN care managers, 1 FTE dietician and 1 FTE primary care pharmacist. These two new clinics directly address the regional goal of expanding primary care capacity to serve Medicaid and indigent patients and by recruiting and retaining a primary care force needed to address critical chronic disease and prevention needs.

**Quality:**

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Region 6 goals:**

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to
better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

**Starting Point/Baseline:**

UT Medicine San Antonio is the practice plan of the School of Medicine at UTHSCSA. Currently primary care visits account for less than 9% of the total yearly visits (100K visits of the 1.1 million visits during the last year). In terms of unduplicated adult patients, all the primary care clinics at UT Medicine only cared for 39,818 unduplicated patients over the last 2 years (June 2010-May 2012). There is clearly a need to grow the primary care footprint of UT Medicine to better serve our community and reap the benefits of primary care for our community. Currently only 2 of 7 primary care clinics offer behavioral health services and only one offers case management by RN on a pilot basis.

**Rationale:**

The RHP6 Needs Assessment identifies significant gaps in the number of primary care clinicians who practice in the region and thus lacks the capacity to care for common chronic diseases (e.g., diabetes and heart disease), provide clinical preventive services (e.g., colon cancer screening and breast cancer screening), and in the treatment of obesity and tobacco use disorder. Treatment of behavioral problems is also a big gap identified in this assessment. These gaps are effectively addressed by primary care and behavioral services that are integrated and community responsive. Moreover, building clinics such as the ones proposed here will help attract and retain more primary care clinicians to the region. The known prevalence of diabetes in Bexar County is 10% and more than double for African Americans (14%) and Hispanics (13%) compared to 6% among Non-Hispanic Whites. Hispanics account for 54% of residents in the region. A significant proportion of Bexar County residents, 67%, are obese or overweight and 23% are sedentary.

With the current direction of health reform towards ACOs and other arrangements featuring population management and some form of prospective payment, it is imperative that the RHP6 develops local experience and expertise with state-of-the-art care delivery systems to appropriately manage population risk, improve quality indicators, and achieve cost savings through reductions in avoidable morbidity (i.e., inappropriate visits to emergency departments and avoidable hospitalizations). Many PCMH projects using care management and related protocols are achieving cost savings of 20-30% and demonstrating positive returns on investment. In order to achieve these outcomes is imperative to have a critical mass of primary care clinics and behavioral health services to allow the expression of these benefits. We are not aware of any related U.S. Department of Health and Human Services underway at UTHSCSA.

CN.2 Reduce health disparities by expanding access to integrated primary care services
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

**Related Category 3 Outcome Measure(s):**

We selected IT 1.11 Diabetes care: \(BP\) control \(<140/90\text{mm Hg}\) NQF 0061 (Standalone measure) as our Category 3 outcome measure. Diabetes is one of the most costly and
highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. The known prevalence of diabetes in Bexar County is 10% and more than double for African Americans (14%) and Hispanics (13%) compared to 6% among Non-Hispanic Whites. Hispanics represent 54% of residents of RHP 6. These estimates do not account for undiagnosed diabetics and pre-diabetics. A highly functional primary care office in addition to increasing access will improve the quality of care for diabetics and hypertensives. The system changes needed to achieve this outcome will benefit both diabetic and hypertensive patients treated at these clinics with substantial savings preventing major complications from both diseases. These conditions are more prevalent among low-income populations because of their higher prevalence of obesity and sedentary lifestyle.

**Relationship to other Projects:**
The project will support and reinforce the “Health Workforce Training to Support Patient-Centered Medical Homes” project. The training curriculum developed for the medical assistants will be directly relevant to that project as will lessons learned about implementing elements of the medical home. This project will also benefit from the “Expanding chronic care management in a safety net clinic” in that the training and protocols developed for this project will directly benefit the RN case managers that will be part of the new clinics. The risk stratification methods used for that project would also be useful for the functioning of the new clinics. There is ongoing close coordination at the leadership level among these projects.

**Relationship to Other Performing Providers’ Projects in the RHP:**
It is our intention to synergize with other projects that are in the process of implementing primary care transformation efforts conducted by University Health System, Community Medicine Associates and other RHP 6. We have a history of collaboration and joined projects that will facilitate close collaboration.

**Plan for Learning Collaborative:**
We are ready to participate and lead if necessary the development of RHP-wide learning collaborative with other providers with similar projects. We have substantial experience in planning and executing these. Dr. Jaén was the Principal Investigator of the team that evaluated the first National Demonstration Project of the Patient-Centered Medical Home. We can work closely with the leadership of the RHP 6 to make this process a reality.
**Project Valuation:**

Achieves waiver goals (score 5): The project directly addresses waiver goals, with its objectives to assure that patients receive high-quality and patient-centered care in the most cost effective ways; improves health care infrastructure by expanding primary care and behavioral health access care access; further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth by avoiding expensive emergency department visits and improving preventive and chronic disease care.

Addresses community needs (score 5): The project directly addresses multiple community needs including the recruitment and retention of a primary care workforce and thus addressing the shortage and access to primary care; addresses the need to have integrated behavioral health and primary care services; and directly addresses cardiovascular disease, cancer and diabetes, three of the top causes of death in the region.

Project Scope – (score 5) – By the end of this project, the region will have 10 additional primary care and behavioral health clinicians practicing in the community. The primary care capacity of UT Medicine will be increased by 25% to almost 50,000 unduplicated patients in all primary care clinics from a baseline of 39,818. A recently published article in Health Affairs provides us with an estimate of savings (Z. Song, D. G. Safran, B. E. Landon et al., “The ‘Alternative Quality Contract,’ Based on a Global Budget, Lowered Medical Spending and Improved Quality,” Health Affairs Web First, published online July 11, 2012.) Properly implemented changes similar to those proposed here provide savings as high as $22.58 per member per quarter. At the end of the project we expect to be caring for a panel of 9600 patients. At this rate the value in savings to the system could be as high as $867,072 at the final year in savings to the region.

Project Investment – (score 5) – The expected capital investment in human resources, lease, equipment, medical supplies, IT infrastructure and support, and time to implement is relatively large. The sustainability of the project is risky in that it requires a significant change in the payment structure for primary care from a fee-for-service only to a medical home blended payment similar to those implemented in other states.
<table>
<thead>
<tr>
<th>085144601.1.11 PASS 1</th>
<th>1.1.1</th>
<th>N/A</th>
<th>1.1.1 Establish more primary care clinics: Primary Care and Behavioral Care Capacity Expansion at UT Medicine San Antonio</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td>Diabetes care: BP control (&lt;140/90mm Hg) NQF 0061</td>
<td></td>
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</table>

| Related Category 3 Outcome Measure(s): | 085144601.3.13 | 3.IT-1.11 |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>P-1 Establish additional primary care clinic #1</td>
<td>P-5 Hire additional primary care providers and staff</td>
<td>I-12 Increase primary care clinic volume of visits and evidence of improved access for patient seeking services</td>
<td>P-1 Establish additional primary care clinic #2</td>
</tr>
<tr>
<td>Metric 1: P-1.1 Number of additional clinics</td>
<td>Metric 1: P-5.1 Documentation of increased number of providers and staff</td>
<td>Metric 1: I-12.2 Increase number of total unique patients treated (patient assigned to panel)</td>
<td>Metric 1: P-1.1 Number of additional clinics</td>
</tr>
<tr>
<td>Baseline/Goal: New clinic</td>
<td>Baseline/Goal: Hire clinicians (2 MDs, 0.5FTE psychologist; 0.5 FTE pharmacist)</td>
<td>Baseline/Goal: Zero/4000 unique patients</td>
<td>Baseline/Goal: Second clinic</td>
</tr>
<tr>
<td>Data Source: P-1.1a Documentation of detailed expansion plans.</td>
<td>Data Source: P-5.1a Documentation of detailed expansion plans.</td>
<td>Data Source: Epic Cadence (Scheduling)</td>
<td>Data Source: P1.1a</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $864,450</td>
<td>Milestone 3 Estimated Incentive Payment: $632,849</td>
<td>Milestone 4 Estimated Incentive Payment: $2,031,004</td>
<td></td>
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</tbody>
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<thead>
<tr>
<th><strong>Milestone 5</strong></th>
<th><strong>Milestone 6</strong></th>
<th><strong>Milestone 7</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I-12 Increase primary care clinic volume of and evidence of improved access for patients seeking services</td>
<td>I-12 Increase primary care clinic volume of and evidence of improved access for patients seeking services</td>
<td>I-12 Increase primary care clinic volume of and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 2: I-12.1 Documentation of increased number of visits. Total number of visits during the previous year. Baseline/Goal: 12,000 visits/Increase of 5% over previous year baseline in clinic #1 or 12,600 visits. 1000 visits for clinic #2</td>
<td>Metric 2: I-12.1 Documentation of increased number of visits. Total number of visits during the previous year. Baseline/Goal: 12,000 visits/Increase of 5% over previous year baseline in clinic #1 or 12,600 visits. 1000 visits for clinic #2</td>
<td>Metric 2: I-12.2 Documentation of increased number of unique patients, or size of patient panel. Demonstrate improvement over previous reporting period. Total number of patients encountered in the clinics over last 2 years. Goal: 5% increase in panel size or 4000 in clinic #2 and</td>
</tr>
<tr>
<td>Data Source: Epic Cadence (Scheduling)</td>
<td>Data Source: Epic Cadence (Scheduling)</td>
<td>Data Source: Epic Cadence (Scheduling)</td>
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<tr>
<td>Milestone 2 Estimated Incentive Payment: $864,450</td>
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<tr>
<td>Documentation of written plan noting appropriate mix of specialty, provider type (MDs, NPs, etc), staffing mix, and geographic location for clinic #2</td>
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<tr>
<td>Milestone 4 Estimated Incentive Payment: $632,849</td>
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<tr>
<td>Milestone 5</td>
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<tr>
<td>P-5 Hire additional primary care providers and staff for second clinic.</td>
<td></td>
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<tr>
<td><strong>Metric 1: P-5.1</strong> Documentation of increased number of providers and staff</td>
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<tr>
<td>Baseline/Goal: Hire additional clinicians (2 MDs, 2 NP/PA, 0.5FTE psychologist, 0.5 pharmacist)</td>
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<tr>
<td>Data Source: P-5.1 a HR records</td>
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<tr>
<td>Milestone 5 estimated incentive payment: $632,849</td>
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<thead>
<tr>
<th>Milestone 6 Estimated Incentive Payment: $632,849</th>
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<tbody>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $981,161</td>
</tr>
<tr>
<td>Milestone 8</td>
</tr>
<tr>
<td>I-12 Increase primary care clinic volume of visits and evidence of improved access for patient seeking services</td>
</tr>
<tr>
<td><strong>Metric 1: I-12.1</strong> Documentation of increased number of visits. Total number of visits during the previous year.</td>
</tr>
<tr>
<td>Goal: Increase of 6% over previous year in clinic #1 or 12,720 visits and 12,000 in clinic #2.</td>
</tr>
<tr>
<td>Data Source: Epic Cadence (Scheduling)</td>
</tr>
<tr>
<td><strong>Metric 2: I-12.2</strong> Documentation of increased number of unique patients, or size of patient panel. Demonstrate improvement over previous reporting period. Total number of patients encountered in the clinic over last 2 years.</td>
</tr>
<tr>
<td>Goal: 17% increase in panel</td>
</tr>
<tr>
<td>Milestone</td>
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<tr>
<td>Year 2</td>
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<td>Year 4</td>
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<tr>
<td>Year 5</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $7,620,774
Title: 1.8.6 Increase, expand and enhance dental services
Unique RHP ID#: 085144601.1.12 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio - Dr. Kenneth M Hargreaves
Performing Provider TPI: 085144601

**Project Summary:**

Provider Description:

The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. The primary mission of the UTHSCSA Dental School is to educate the future dental workforce for the state of Texas. In order to accomplish that goal, the Dental School requires an adequate patient pool to ensure that all of our dental students and residents receive the training required to attain competency to practice dentistry in Texas. Accordingly, the UTHSCSA Dental School does not require income verification in order to become a patient at the Dental School. We do however track patients by source of payment. Approximately 70% of the Dental School patients in all of the clinics in the school are identified as "self-pay" patients (dentally uninsured). In order to determine whether or not a patient is indigent, the DS can run a query, sorting patients by zip code and then ascertaining what % of the population in each specific zip code fall below the Federal Poverty Level (FPL). If we apply that Zip code percentage below the FPL to patients from the same Zip Code, we can estimate the % of indigent patients treated by the Dental School.

Also, we do obtain/track information (payor status) for children enrolled in Medicaid CHIP, and Title V at the DS and off-site clinics on the same clinic information system. In order to determine the percentage of adult who are eligible/enrolled in Medicaid for Medical benefits, but not dental benefits, we could add that element to our certified electronic health record. This would be proof of indigent status even though Medicaid does not cover adult dental benefits in Texas. It is assumed that the majority of the patients who would seek emergency dental care in the new clinic are going to be adults (Self-paying).

Most Dental Schools in the US have similar clinical operations due to the common primary goal of educating the future dental workforce and the requirement have adequate patient pools to attain our outcomes. In order to increase our pool of indigent/uninsured patients we will need to establish this baseline without requiring income verification in order not to undermine the total patient pool. Generally speaking, the indigent population also presents with the greatest treatment needs and therefore are very good teaching cases. The challenge for uninsured adults in the country who are indigent to be able to afford comprehensive dental care, The goal of the Emergency Dental Clinic proposal is to increase access to "emergency dental care" while simultaneously controlling costs and educating future workforce. The intent is to address the patient’s chief complaint in a timely manner at a reasonable price. A secondary goal is to educate the patients that present for emergency care about the importance of treating active dental disease and to encourage this cohort of patients to seek primary care to restore them to health and then to encourage them to seek regular dental care, including
prevention. This approach is not designed to restore full function, that is, to provide comprehensive rehabilitative care, but rather to encourage this cohort of patients to work towards that goal. Some people will choose not to seek comprehensive dental care due to the costs which are not covered by Medicaid or Medicare. The focus is on urgent care with referrals for primary care and comprehensive care. Hopefully, a segment of this cohort of emergency patients will decide to seek the care they need as the Dental School offers dental care to patients using different fee schedules for care provided by dental students in training, general and specialty residents in training, and dental school faculty. The fees associated with dental student training are considerably lower that the fees associated with care rendered by a faculty member.

**Intervention(s):**

The major goal of this project is to establish an emergency dental clinic for treating patients presenting with urgent dental conditions including oral infections, abscesses, pain and fractured dental restorations. This clinic will provide treatment to resolve the emergency condition and refer patients seeking comprehensive oral care to the UTHSCSA Dental School.

**Need for the project:**

Access to emergency oral health care is a challenging problem that greatly impacts both medical and dental treatment teams. For example, a recent Agency for Healthcare Research and Quality (AHRQ) report demonstrated that the number of hospital ER visits (>830,000) due to oral health emergencies has increased by nearly 16% from 2006-2009 (1). This has major health care resource implications since hospital ER visits for dental emergencies cost nearly ten times more than similar care delivered in a dental office ($6,498/visit versus $660) (2). Development of an emergency dental clinic is likely to have major community impact, particularly since nearly 66% of all emergency room visits for oral emergencies are by patients with a mean annual household income of <$47,000 (3).

**Target population:**

Our web-based survey indicates that low income populations with moderate/severe health disparities comprise the majority of subjects contacting the UTHSCSA Dental Clinic with requests for access to emergency/urgent dental care. Thus, the focus on these outcomes directly addresses a health care issue in this population.

**Category 1 or 2 expected patient benefits:**

As described above, a hospital ER visit for emergency oral health care costs about $6,498/visit. The enclosed Table lists the projected numbers of patients and incentive payments for each year. In the aggregate, the total incentive costs are $6,724,213 for treating a projected 8,917 patient visits, giving a calculated cost of $1,006/patient visit. Thus, considerable value is added by establishing this oral health care emergency clinic. Given that the UTHSCSA Dental School is an academic institution with a primary teaching mission, this value is quite similar to the comparison costs for oral health emergency care delivered in a dental office, and much lower than hospital ER costs ($6,498/visit) for dental emergencies (2).

<table>
<thead>
<tr>
<th>Year</th>
<th>Projected #</th>
<th>Projected #</th>
<th>Incentive</th>
<th>Valuation</th>
</tr>
</thead>
</table>

466 ★ RHP 6 Plan ★ March 8, 2013  UTHSCSA
### Category 3 outcomes:

The category 3 patient benefit is a 40% increase in the proportion of indigent and impoverished patients treated over baseline values.

### Project Description:

The major goal of this project is to establish an emergency dental clinic for treating patients presenting with urgent dental conditions including oral infections, abscesses, pain and fractured dental restorations. This clinic will provide treatment to resolve the emergency condition and refer patients seeking comprehensive oral care to the UTHSCSA Dental School. It is important to note that this is a new entity since existing hospital emergency rooms or dental clinics only offer limited and/or irreversible treatments consisting of extractions. Access to emergency oral health care is a challenging problem that greatly impacts both medical and dental treatment teams. For example, a recent Agency for Healthcare Research and Quality (AHRQ) report demonstrated that the number of hospital ER visits (> 830,000) due to oral health emergencies has increased by nearly 16% from 2006-2009 (1). This has major health care resource implications since hospital ER visits for dental emergencies cost nearly ten times more than similar care delivered in a dental office ($6,498/visit versus $660) (2). Development of an emergency dental clinic is likely to have major community impact, particularly since nearly 66% of all emergency room visits for oral emergencies are by patients with a mean annual household income of <$47,000 (3). Despite this widely recognized problem, no current emergency dental clinic exists in Bexar Country that offers any form of treatment other than an irreversible extraction, leading to a major negative impact on long-term stable oral health. In addition, this Clinic will develop a triage service that bridges emergency treatment to dental providers that can provide comprehensive care. This service will directly benefit patients, by increased oral health, as well as providing increased training opportunities for students and residents at the UTHSCSA Dental School.

### Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

### Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and
maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

The UTHSCSA Dental School developed an online patient screening website application in 2007 (4). This application collects demographic information and preliminary oral health history information that is maintained in a secure database. As of July 12, 2012, a total of 32,824 records have been entered by prospective patients. An analysis of this database indicates that there is a large unmet need for treating oral emergencies. Nearly 55% of the 32,824 records included patients who entered at least one of the following keywords indicative of a need for emergency/urgent care: “pain”, “ache”, “hurt”, “broken”, “toothache”, “emergency”, “swollen” or “swelling”. Moreover, we have conducted a Geo Map analysis of the subjects entering these keywords for the top 20 most frequently used home zip codes (Fig 1). The top 20 zip codes entered by these subjects were represented in ~42% of all online records using the key words listed above.

Two major conclusions emerge from this analysis. First, the UTHSCSA Dental School has a large catchment zone that includes broad representation across our community. However, the second finding is even more significant. The zip codes most frequently used by prospective emergency dental patients are highly linked to elevated scores on the Community Needs Index (CNI; see Fig 1). The CNI identifies the severity of health disparity for every zip code in the United States (5,6). It is a composite measure of income barriers, culture/language barriers, education barriers, insurance barriers and housing barriers. The CNI ranges from 1 (lowest socioeconomic barriers) to 5 (highest socio-economic barriers). There is >95% correlation between CNI scores and hospitalization rates, with admission rates for communities with CNI scores of 5 being ~60% greater than rates observed in communities with CNI scores of 1 (5). Importantly, the mean CNI score for the top 20 zip codes in our database is 3.7. This analysis clearly demonstrates that there is strong need for an emergency dental clinic at UTHSCSA and that such a clinic will directly address populations with substantial health disparities.
To specifically relate this to the December 2011 starting point, we have re-analyzed the online patient screening database for Dec 2011 and found 100 patients who reported dental emergencies via this internet based application.

References

**Rationale:**

Reasons for selecting the project option: Access to emergency oral health care is a challenging problem that greatly impacts both medical and dental treatment teams. For example, a recent Agency for Healthcare Research and Quality (AHRQ) report demonstrated that the number of hospital ER visits (> 830,000) due to oral health emergencies has increased by nearly 16% from 2006-2009 (1). This has major health care resource implications since hospital ER visits for dental emergencies cost nearly ten times more than similar care delivered in a dental office ($6,498/visit versus $660) (2). Development of an emergency dental clinic is likely to have major community impact, particularly since nearly 66% of all emergency room visits for oral emergencies are by patients with a mean annual household income of <$47,000 (3). Despite this widely recognized problem, no current emergency dental clinic exists in Bexar Country that offers any form of treatment other than an irreversible extraction, leading to a major negative impact on long-term stable oral health.

Unique Community Need Identification Number: This project relates to RHP 6 Community Needs Assessment-Current Healthcare Infrastructure & Health Care Quality.

Access to emergency oral health care is a challenging problem that greatly impacts both medical and dental treatment teams. For example, a recent Agency for Healthcare Research and Quality (AHRQ) report demonstrated that the number of hospital ER visits (> 830,000) due to oral health emergencies has increased by nearly 16% from 2006-2009 (1). This has major health care resource implications since hospital ER visits for dental emergencies cost nearly ten times more than similar care delivered in a dental office ($6,498/visit versus $660) (2). Development of an emergency dental clinic is likely to have major community impact, particularly since nearly 66% of all emergency room visits for oral emergencies are by patients with a mean annual household income of <$47,000 (3). Despite this widely recognized problem, no current emergency dental clinic exists in Bexar Country that offers any form of treatment other than an irreversible extraction, leading to a major negative impact on long-term stable oral health. Therefore, this is a new initiative.

CN.3 Addresses the community need for improved access to dental services.

References:

**Related Category 3 Outcome Measure(s):**

We have selected IT-7.10. Other Outcome Improvement Target: Proportion of children and adults with urgent dental care needs *(Stand alone measure)*

a Numerator: Number of children and adults with urgent dental care needs
b Denominator: Total number of patients seen by a dental provider
c Data Source: EHR, Claims
d Rationale/Evidence: patients are less likely to suffer from more severe, urgent oral health
problems with adequate and regular access to dental care

- This outcome should be a priority for the RHP since it directly addresses a community need for emergency/urgent dental care. Data are described in “Starting Point/Baseline” section, above.
- The proposed Category 1 project will help achieve this Category 3 outcome measure by providing emergency/urgent dental care to children and adult (including geriatric) patients. Thus, each patient treated contributes directly to the numerator for this Outcome Measure.
- As described above in the “Starting Point/Baseline” section, our web-based survey indicates that low income populations with moderate/severe health disparities comprise the majority of subjects contacting the UTHSCSA Dental Clinic with requests for access to emergency/urgent dental care. Thus, the focus on these outcomes directly addresses a health care issue in this population.

Relationship to other Projects:
This project is related to the UTHSCSA Dental School IT project (1.8) in that this project establishes a new clinic within the DS which will rely on the IT project to provide the data source including core clinical quality outcome indicators required of certified EHR’s for all patients treated for emergency dental care, allowing us to analyze results and assess impact. Also, this project is related to the San Antonio Metropolitan Health District’s School-Based prevention project, in that the DS Emergency Dental Clinic will serve as a referral site for children identified as having “urgent need” for dental care as well as connection to a pediatric dental care clinic for children who need comprehensive care and do not have a dental home.

Relationship to Other Performing Providers’ Projects in the RHP:
We will be collaborating closely with Dr. Gary Guest, Interim Associate Dean for Patient Care at the DS and project director for the IT project, regarding the integration of the Emergency Dental Care Clinic into the DS clinical infrastructure as staffing of this clinic will require the collaboration of several disciplines in addressing the patients with urgent care visits, including Oral Surgery, Endodontics, Advanced General Dentistry, and Pediatric Dentistry. The residency directors of these disciplines will be involved in the Learning Collaborative to enable us to develop a schedule that will allow us to treat the patient’s urgent need in this new clinic as well as provide an academic framework for cross fertilization, teaching dental students and residents in the same environment.

Plan for Learning Collaborative:
Since the DS is building a new 200,000 sq. ft. clinical/research facility with 350 operatories will open in 2015, it will be essential to establish a Learning Collaborative that includes Faculty within the DS collaborating to integrate the Emergency Dental Care Clinic into the overall Mission and Goals of the institution as well as linking the departmental goals and objectives together for the good of the patient. As mentioned, the IT project provides the necessary foundation for data collection and analysis to enable successful implementation of this project. Because the educational mission of dental schools is to graduate competent general dental practitioners, a significant portion of the curriculum and clinical training is focused on the treatment of adults and as we are all aware, Medicaid does not cover adult dental benefits, making it difficult for Dental Schools in the nation to qualify for the Electronic Health Record Incentive program in terms of the 30% rule. However, in preparation for the opening of the new DS, the DS has ordered the certified edition of the AxiUm software. All of the faculty, residents,
staff and students will be trained via the IT project to use the new software – this also requires a
great deal of coordination, collaboration and efficiency so as to avoid interruption of the
academic, research, and clinical missions of the DS. Also, since this project will depend upon
staffing from various departments as well as calibration of training in operation of an ER Dental
clinic, developing a referral base form various sources, and integrating sustainability in an
uninsured patient pool environment, the Learning Collaborative will need to include partners
outside the DS, including the Dental Coordinator from the San Antonio Metropolitan Health
District. The DS Emergency Care Clinic will serve as the referral site for children having urgent
care needs. Other partners may be added to address specific issues that arise.

**Project Valuation:**

Achieves Waiver Goals (Self-Score =5): This project will develop a new dental care clinic for
treating emergency/urgent care patients and provides new training and rotations for dental
students and residents. As cited above, the cost of treating dental emergency patients in a dental
clinic is about 10% of the cost of treatment provided in the ER. Thus, this project addresses the
Triple Aim by providing high quality and patient centered care in a cost effective manner. It also
directly improves the health care infrastructure by BOTH establishing a new dental care clinic
and reducing the volume of patients who otherwise may use hospital ER services. Since ER
services often are only extractions, the dental clinic treatments would improve health outcomes
by saving teeth.

Addresses Community Needs (Self-Score =5): As indicated above, nearly 55% of the 32,824
patient contacts to the UTHSCSA Dental School requested emergency/urgent care treatment.
Since this sample only included patients who had access to the internet and knew about the
dental school clinic website, it likely represents a large under-estimate of the actual community
need. Moreover, our GeoMapping analysis reveals that these patient contacts occurred from our
RHP zip codes with particularly high socio-economic barriers (see Fig above). Thus, this
project application documents a strong community need for emergency/urgent dental care that is
based both upon literature review and direct analysis of our RHP’s population.

Project Scope (Self-Score = 4): This project scope is large in impact from four perspectives.
First, it provides a new dental care clinic that does not currently exist. Second, it will employ
expanded hours to increase patient visits/encounters. Third, it will involve training of both
dental students and residents to treat these populations increasing the number of recruited/
trained practitioners for the population living in the borders of RHP 6. Fourth, it will provide
savings from avoiding unnecessary ER visits.

Project Investment (Self-Score = 5): This project involves human resources (faculty, staff, dental
students, residents), new clinic space, new equipment and time to implement with an overall plan
that integrates improvement and process to achieve the milestones.
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**Related Category 3 Outcome Measure(s):**
- 085144601.3.14
- 3.IT-7.10
- Other Outcome Improvement Target

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**Milestone 1**
- [P4]: Establish additional/expand existing/relocate dental care clinics or space
  - Metric 1 [P4.1]: Number of additional clinics, expanded space, or existing available space used to capacity
    - Baseline/Goal: purchase equipment for 3 operatories of the emergency clinic
    - Data Source: Equipment lists

  Milestone 1 Estimated Incentive Payment: $508,500

**Milestone 2**
- [P5]: Expand the hours of a dental care clinic or office, including both evening and/or weekend hours
  - Metric 1 [P5.1]: Develop policies for expanded hours for

  Milestone 2 Estimated Incentive Payment: $558,396

**Milestone 4**
- [P-4]: Establish additional/expand existing/relocate dental care clinics or space
  - Metric 1 [P-4.1]: Number of additional clinics, expanded space, or existing available space used to capacity
    - Baseline/Goal: Increased number of treatment rooms by 2.
    - Data Source: Building plans showing new emergency clinic.

  Milestone 4 Estimated Incentive Payment: $508,500

**Milestone 5**
- [I-12]: Increase the number of patients treated by fourth year dental students and dental residents during special population externships and rotations

  Milestone 5 Estimated Incentive Payment: $896,031

**Milestone 7**
- [I-12]: Increase the number of patients treated by fourth year dental students and dental residents during special population externships and rotations

  Milestone 7 Estimated Incentive Payment: $865,731

**Milestone 9**
- [I-12]: Increase the number of patients treated by dental students and dental residents during special population externships and rotations
  - Metric 1 [I-12.1]: Increase number of emergency patients treated by fourth year dental students and dental residents during externship/rotation training opportunities
    - Goal: Treat 3,492 patients totaling 3,880 patient volume
    - Data Source: patient charts

  Milestone 9 Estimated Incentive Payment: $865,731

**Milestone 10**
- [I-11]: Increase dental care training
  - Metric 1 [I-11.2]: Increase # dental residents/students
**new Dental Emergency Clinic**

**Baseline/Goal:** Hire one additional faculty FTE and 2 staff in order to increase number of hours at emergency clinic over baseline.

**Data Source:** Clinic Policies and Procedures Manual, 1) Faculty Payroll; 2) Staff Payroll

Milestone 2 Estimated Incentive Payment: $508,500

**Milestone 3**

[P-1]: Enhance and expand dental provider training  
**Metric 1 [P1.2]:** Expand/increase rotations, continuing education, in-service trainings, lunch and learn presentations for dental residents and private practice dentists to enhance their exposure and experience providing dental services to special populations such as elderly, pregnant women, young children, medically compromised and/or special needs.  
**Baseline/Goal:** Develop at least 5 lectures/objectives for externships and rotations

Milestone 3 Estimated Incentive Payment: $558,396

**Milestone 6**

[P-1]: Increase dental care training and increase # dental residents participating  
**Metric 1 [P-1.2]:** Expand/increase rotations, continuing education, in-service trainings, lunch and learn presentations for dental residents and private practice dentists to enhance their exposure and experience providing dental services to special populations such as elderly, pregnant women, young children, medically compromised and/or special needs.

**Baseline/Goal:** Treat 720 patients (totaling 800 patient visits)  
**Data Source:** patient schedule

Milestone 5 Estimated Incentive Payment: $558,396

Milestone 8 Estimated Incentive Payment: $896,031

Milestone 10 Estimated Incentive Payment: $865,731

**Metric 1 [I-11.2]:** Increase # dental residents/students participating in the externship opportunities, number of rotations, continuing education, in-service training, and lunch and learn presentations  
**Goal:** Increased number of dental students and residents participating in rotations in the clinic by 2 trainees  
**Data Source:** rotation schedule

**Metric 1 [I-12.1]:** Increase number of emergency patients treated by dental students and dental residents during externship/rotation training opportunities  
**Baseline/Goal:** Treat 720 patients (totaling 800 patient visits)  
**Data Source:** patient schedule

Milestone 6 Estimated Incentive Payment: $558,396
| Milestone 3 Estimated Incentive Payment: $508,500 | Baseline/Goal: Increased number of dental students and residents participating in rotations in the clinic by 3 trainees | Data Source: Participation Roster |
| Milestone 6 Estimated Incentive Payment: $558,396 |

| Year 2 Estimated Milestone Bundle Amount: $1,525,501 | Year 3 Estimated Milestone Bundle Amount: $1,675,189 | Year 4 Estimated Milestone Bundle Amount: $1,792,062 | Year 5 Estimated Milestone Bundle Amount: $1,731,461 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,724,213**
# Identifying Project and Provider Information:

| Title: 1.8.12 Other project option to enhance oral health services: Electronic Health Record |
| Unique RHP ID#: 085144601.1.13 – PASS 1 |
| Performing Provider: University of Texas Health Science Center - Dr. Gary Guest |
| Performing Provider TPI: 085144601 |

## Project Summary:

**Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. The primary mission of the UTHSCSA Dental School is to educate the future dental workforce for the state of Texas. In order to accomplish that goal, the Dental School requires an adequate patient pool to ensure that all of our dental students and residents receive the training required to attain competency to practice dentistry/specialty practice in Texas. Accordingly, the UTHSCSA Dental School does not require income verification in order to become a patient at the Dental School. We do however track patients by source of payment. Approximately 70% of the Dental School patients in all of the clinics in the school are identified as "self-pay" patients (dentally uninsured). Through our Electronic Health Record system we will be able to track patients by financial class and determine percentage of patients that are low income, including those below federal poverty level. We will also capture information related to Medicaid status.

### Intervention(s):

Upgrade the oral healthcare IT infrastructure to be used with Certified Software in support of the dental treatment of all patients served by the Dental School, including special populations and mothers, infants, and children. The certified version of the EHR incorporates core clinical quality measures allowing for the tracking of medical conditions related to dental health status, and the treatment of special needs patients.

### Need for the project:

The RHP Planning protocols delineate Specific Project Goals which include, the enhancement of quality dental care but does not include an option to provide training and use of the use of a certified electronic health record. The Federal government supports the use of the certified EPR to enhance quality as demonstrated by the EHR Incentive Program that has established and standardized clinical quality measures. Training of all clinic personnel in an academic dental school setting will facilitate automated reporting and allow providers to track patient demographics, diagnoses, treatment status, referrals, and cost of care which is essential to improving quality and providing quality assurance. The system will expand performance improvement and reporting capacity through participation in a clinical database for standardized data sharing and the development of a quality dashboard that is shared with faculty in the DS as well as with faculty in all other Dental Schools in the US who are using the Certified version of the Electronic Health Record. The system will also provide actionable quality data, streamline the specialty provider referral process, and enhance coordination of patient care at all DS sites. Referral will lead to joint consultation and treatment planning to improve patient education and
treatment as well as performance.

Target population (focus on quality of clinical care):

The Dental School Electronic Health Record will allow analysis of all patients to enable us to assess the quality of care rendered, provide effective care and focus on patient safety. This includes tracking key Quality Clinical Measures as designated by “Meaningful Use Rule” (tobacco use, diabetes, hypertension, drug and alcohol use etc). Our web-based survey indicates that low income populations with moderate/severe health disparities comprise the majority of subjects contacting the UTHSCSA Dental Clinic with requests for access to dental care. Thus, the focus on these outcomes directly addresses a health care issue in this population.

Category 1 or 2 expected patient benefits:

Expected patient benefit will be linked to standards of care, treatment outcomes, patient satisfaction survey results, health care provider compliance. The focus on quality of patient care is anticipated to enhance the benefit for all patients in the Dental School Clinic.

Category 3 outcomes:

The category 3 benefit relates to the implementation of the certified electronic record, training of users, analysis of patient data to support quality measures. This information will enable us to make necessary changes to improve oral health quality. Our benchmark for compliance will be 85% after year 3 implementation with goal of 95-100% in year 4. Expected result: to drive quality improvement through enhanced completion and information sharing.

Project Description:

The UTHSCSA Dental School (DS) is building a new 200,000 sq. ft. dental clinical/research facility which will be equipped with state-of-the-art dental equipment and information technology (350 dental operatories). Our existing clinic information system will be replaced with a “certified” electronic health record system (axiUm software). The goal of this proposal is to upgrade the oral healthcare infrastructure to be used with the certified software to support the dental treatment of all patients served by the Dental School, including special populations and mothers, infants, and children. In Bexar County, 57% of children enrolled in Head Start were found to have dental caries. Many of these children will receive basic dental care at the Ricardo Salinas Clinic owned by the San Antonio Housing Authority and operated by the DS and this clinic will be included in the network using the enhanced technology infrastructure. In order to accomplish this goal, the DS will need to upgrade the hardware technology and network systems throughout all of the clinics and to prepare the entire dental school workforce and future graduates of UTHSCSA Dental School to utilize an electronic health record (EHR). Funding for E.H.R. (Certified Version) has been provided through Meaningful use incentive payment. This was for software only. The certified version of the EHR incorporates core clinical quality measures to enable us to track medical conditions related to dental health status, as well as to track the treatment of special needs patients, improve quality controls, facilitate referrals to specialty providers as needed and enhance coordination of patient care at all DS sites. Results of queries from this type of system can be displayed, mapped and exported in multiple machine readable formats for customized data analysis and or the ability to combine multiple datasets for larger population analysis. The axiUm system that will be used by the DS has the capacity to integrate with a DICOM imaging system, MiPACS. This system has analytical tools that can
assist in quantification of findings that in turn can be utilized as quality improvement efforts. Standardized data elements related to radiographic analysis from images in MIPACS will be added to axiUm EHR. The Dental School will also utilize site licensing for a Drug Information System and Patient Education Software designed to improve the quality of patient care. Information from the Drug Information System will be integrated into the AxiUm EHR along with surveys of patient behavior related to digital forms of patient education materials. Faculty, students, staff and residents will be trained in the use of clinical modules of the EMR as part of their provision of dental care. Challenges: Our current CIS is outdated and does not include the clinical quality measures included in the certified version and DS personnel are not trained in the usage of this new system. Implementation will require significant training of all personnel without negatively impacting the delivery of dental care. Also, determining how to aggregate information in the EHR in a meaningful way will require accurate and precise data elements that need to be developed. All new/updated hardware and network systems will be required and will have to be integrated with the new certified software at all sites. The Dental School provides approximately 120,000 patient visits per year at its main clinical facility and off-site clinical training sites, serving as a safety net for dental patients in South Texas, most of whom are dentally uninsured and cannot afford dental care in the private sector. For every medically uninsured individual in Texas, approximately 2.6 individuals are dentally uninsured. This proposal supports the Emergency dental care proposal. Clinical Informatics System Project applies to all patients served (unduplicated -10,000 patients in the dental school clinic per year in San Antonio). Clinical Informatics System Project applies to all dental care services provided to all patients at each patient visit.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

The Dental School provides approximately 120,000 patient visits/encounters per year (FY 2012) at its main clinical facility and off-site clinical training sites, serving as a safety net for dental patients in South Texas, most of whom are dentally uninsured and cannot afford dental care in the private sector. Currently none of the DS providers have been trained on the Certified Edition of the axiUm EHR. Approximately 500 individuals will be trained in the use of the Certified Edition of the axiUm EHR in year 2 (2013); all new entering students as well as new faculty and staff will be trained in subsequent years (2014-2016)
Rationale:

The primary reason for selecting this project is the need to adequately prepare our students and residents to practice in an environment where they will have the capability to assess their own performance and the quality of the care provided to their patients as well as the need to improve the oral healthcare technology infrastructure. The Dental School's goal is to teach students and residents to use best practices and practice evidence-based dentistry upon graduation, including the attainment of competence in the treatment of patients, including special populations. The milestones and metrics relate to the IT training of the entire Dental School personnel enterprise which includes approximately 400 dental students, 120 residents, 200 faculty and 125 staff. As specified in the Community Needs Assessment, a high dental caries rate (57%) was reported in Bexar County children enrolled in Head Start. Also, 11 of the 20 counties in RHP 6 are designated entire county dental HPSA’s and Bexar County is designated as a partial county dental HPSA. Other problems include: limited access to dental care, high dentally uninsured patient rates, and lack of dental providers. Recent prospects in the job market due to drilling for natural gas are expected to increase the population in this region and presumably a demand for health care services, including oral health care services. A comprehensive report by the Texas Department of State Health Services, *Oral Health in Texas 2008* provides a snapshot of oral health and the distribution of oral health problems among Texas residents. “Infections in the mouth, such as periodontal disease can increase the risk of heart disease (Beck at al.1998). Periodontal disease has also been associated with pre-term delivery (Scannapieco, et al, 2003) and complicates the control of blood sugar for people with diabetes (Taylor 12001).” We expect to track these parameters among the entire DS patient population, including at DS off-campus sites which serve, children, adults, and the homeless. In order to assess the effectiveness, timeliness and appropriateness of care. “Changes in the mouth often serve as first indicators of problems elsewhere in the body. And infectious diseases, immune disorders, nutritional deficiencies and cancer often first reveal themselves by changes in the mouth” (TDHS). Oral health disparities have been associated with race, ethnicity, sex and socioeconomic class relative to oral health status and access to oral health care. Therefore, this data could be used as indicators of socioeconomic differences in oral health and can be used to analyze the burden of oral disease among patients served by the Dental School. Use of the certified electronic record will also enable us to contribute to the body of scientific evidence related to oral health outcomes and to impact policy and the provision of services thru surveillance. The Clinic Information System/Dental EHR will serve as a data source to measure milestones for the project. The system contains patient record information, clinic schedules, transactional history for both patients and providers, billing information, consent forms and clinical notes. Dental School faculty and staff in the office of Patient Care/Information technology will be responsible for the implementation of the project and for the training of all the Dental School workforce providers involved in the delivery of patient care in the various general and specialty clinics. The DS has already begun the investment by submitting a purchase order to acquire the certified electronic record software thru the EHR Incentive Program. Hardware to support the system, including servers, computers and network upgrades will be needed to enable the implementation of the improved healthcare storage infrastructure project at the new Oral Health Care and Research facility. Training will be phased in by groups of users. Ready access and security arrangements will be made to protect servers by establishing 3 separate hubs on campus independent of the dental school. Since this system underlies the basis of tracking both educational and patient care outcomes, it will need to be in place and the providers trained in order to ensure successful transition to a new facility and
to an updated electronic health record system.

CN.3 This project addresses the need for greater access and enhance quality assessment to dental services for the indigent and Medicaid eligible populations as ascertained from the Certified Electronic System.

Related Category 3 Outcome Measure(s):


The primary reason for selecting this project is the need to adequately prepare our students and residents to practice in an environment where they will have the capability to assess their own performance and the quality of the care provided to their patients as well as the need to improve the oral healthcare technology infrastructure. The Dental School's goal is to teach students and residents to use best practices and practice evidence-based dentistry upon graduation. The milestones and metrics relate to the training of the entire Dental School personnel enterprise which includes approximately 400 dental students, 120 residents, 175 faculty and 125 staff. The current dental care delivery system and dental workforce are currently segregated from the healthcare system, making coordination of care and the attainment of overall health outcomes that are impacted by oral health status impossible. While the technology does not exist to enable electronic health record systems to communicate directly among all providers, the capacity to export relevant oral health status data to healthcare practitioners treating patients with diabetes, heart disease, cancer, etc. can impact patients’ overall health status.

a Numerator: Number of DS faculty, students, residents and staff trained in use of Certified EHR
b Denominator: Total number of faculty, students, residents and staff involved in patient care delivery at the Dental School and Off-campus sites
c Data Source: Training logs/schedules; training materials
d Rationale/Evidence: The ability to impact the effectiveness, timeliness and appropriateness of care within the UTHSCSA dental school and its’ off-campus sites all of which serve low-income populations and to have the capacity to share this information with other providers of health care services and dental educators is critical to maintaining the quality of dental educational institutions. (Fontaine et al).

Relationship to other Projects:

This project supports the UTHSCSA Emergency Care proposal (1.8). This project will enable the DS to track increased access to dental care, improve urgent dental care and improve performance and reporting capacity throughout all of the dental clinics using the same technology. Additionally, the training and upgrading of our electronic information system (hardware) to the utilization of a "certified" electronic record will enable us to provide information relative to many of the medical clinical measures in the DS population which is expected to increase dental care coordination within the dental school and identify patients.

With implementation of the certified system along with project goals database elements and their aggregation into reports, we will be able us to evaluate special populations to address project goals.
**Relationship to Other Performing Providers’ Projects in the RHP:**

We will be collaborating closely with Dr. Ken Hargreaves, Chairman, Department of Endodontics to support the establishment of a new Emergency Dental Care Clinic at the DS and the integration of the Emergency Dental Care Clinic into the DS clinical information technology storage infrastructure. All of this will require significant planning, collaboration of several disciplines in addressing the patients with urgent care visits, including Oral Surgery, Endodontics, Advanced General Dentistry, and Pediatric Dentistry as well as all patients in the Dental Scholl served by the 10 general and specialty disciplines as well as the undergraduate dental school and the dental hygiene clinics (approximately 240 dental operatories).

The residency directors of these disciplines as well as the undergraduate faculty clinic group leaders and dental hygiene faculty will be involved in the Learning Collaborative to enable us to develop a schedule that will allow us to not only treat the large volume of dental patients that present to the dental clinic for dental care on a daily basis. This will also provide the basis for an academic framework for cross fertilization, teaching dental/dental hygiene students and dental residents in the Dental School clinics.

**Plan for Learning Collaborative:**

Since the DS is building a new 200,000 sq. ft. clinical/research facility with 350 dental operatories that will open in 2015, it will be essential to establish a Learning Collaborative that includes faculty and staff within the DS collaborating to integrate the Emergency Dental Care Clinic into the overall Mission and Goals of the institution as well as linking the departmental goals and objectives together for the good of all patients. As mentioned the IT project provides the data collection and analysis necessary for the treatment of all patients. Because the educational mission of dental schools is to graduate competent general dental practitioners, a significant portion of the curriculum and clinical training is focused on the treatment of adults and as we are all aware, Medicaid does not cover adult dental benefits, making it difficult for Dental Schools in the nation to qualify for the Electronic Health Record Incentive program in terms of the 30% rule. However, in preparation for the opening of the new DS, the DS has ordered the certified edition of the axiUm software and will need to upgrade the hardware and network systems as well as train a large cohort of dental workforce personnel in the use of this new technology. All of the faculty, residents, staff and dental/dental hygiene students will be trained via the IT project to use the new software – this also requires a great deal of coordination, collaboration and efficiency so as to avoid interruption of the academic, clinical and research missions of the DS. Also, since the Emergency Care project will also require staffing from various departments as well as calibration of training in operation of an ER Dental clinic, developing a referral base form various sources, and integrating sustainability in an uninsured patient pool environment, the Learning Collaborative will also include partners outside the DS, including the Dental Consultant from the San Antonio Metropolitan Health District. The DS operates a pediatric dentistry clinic owned by the City of San Antonio. Also, the DS operates a 15 chair dental clinic at the Laredo Health Department which is staffed by UTHSCSA Dental School full-time and part-time faculty; this clinic will be incorporated into the upgraded EHR network and a representative from the LHD program will be part of the learning collaborative via video conferencing. Other partners may be added to address specific issues that arise.
Project Valuation:

This project is intended to provide the information infrastructure needed to ensure that patients treated at the Dental School and off-site clinics receive high quality, patient-centered dental care in a cost effective and efficient manner; and that the dental care is coordinated and that better dental care outcomes are attained for all dental school patients, including the uninsured, Medicaid and CHIP as well as Title V and special needs patients. The DS will implement and train the dental school faculty, staff, dental/dental hygiene students and residents in the use of the certified electronic record. Through this project, we will track dental treatment outcomes, cost savings, efficiency of dental care delivery and referral systems within dental school to specialty departments, reduction in dental errors/prosthetic replacements, measure student performance, provide broad array of clinical experiences required to train dentists, dental hygienists, and dental specialists to be competent practitioners, and identify gaps in training needs. The implementation of the certified electronic record, training of users, analysis of patient data to support quality measures. This information will enable us to make necessary changes to improve oral health quality. Our benchmark for compliance (patient records documentation, treatment outcomes, and diagnosis/treatment of oral diseases) will be 85% after year 3 implementation with goal of 95-100% in year 4. The Electronic Record System will be used to coordinate care between general and specialty dentists. Data from this system can aggregated and exported to machine readable formats for data mapping and warehousing to aid in quality of care assessments over multiple systems including systems used by medical providers. We are working with the City of San Antonio/San Antonio Metropolitan Health District to develop data warehousing strategy to assess quality of care for the Children’s Oral Health Initiative. This initiative proposes to provide preventive dental services to 10,000 underserved children in San Antonio / Bexar County. The dental school anticipates that all patients will benefit from the implementation of the Electronic Dental Record which has a significant focus is on quality of care. A value added benefit is the training of future oral health care workforce on use of technology to enhance quality of care.

Achieves Waiver goals: this project focuses on assuring that patients receive high-quality care through monitoring treatment via use of the certified electronic health record. It improves the oral health care infrastructure to better serve all patients, including Medicaid patients and will enable the DS to further develop and maintain an internal coordinated care delivery system. The implementation of this project is expected to improve oral health outcomes while containing cost and minimizing unneeded treatment. This project will also impact the DS urgent care clinic, facilitating reporting and standardization and impacts all patients treated by the DS. The evidence supports implementation of the Certified EHR. Addresses Community Needs: this project supports all of the DS treatment programs and is expected to provide real-time evidence regarding treatment outcomes for patients, including the underserved and uninsured, many of whom seek treatment in the DS. Project Scope: Patient visits/encounters will be tracked for all patients along with clinical core measures, providers will be trained and savings are anticipated due to better coordination of comprehensive dental care. Project Investment: this project involves human resources (faculty, staff, dental students, residents), new clinic facility, new equipment and time to implement with an overall plan that integrates improvement and process to achieve the milestones.

References:
Systematic Review of Health Information Exchange in Primary Care Practices
Patricia Fontaine, MD, MS, Stephen E. Ross, MD, Therese Zink, MD, MPH, & Lisa M. Schilling, MD, MSPH


**EHRs in primary care practices: benefits, challenges, and successful strategies.**
Goetz Goldberg D, Kuzel AJ, Feng LB, DeShazo JP, Love LE.
Department of Health Policy, George Washington University, Center for Healthcare Quality, Washington, DC 20037, USA. goetzdc@gwu.edu

by Richard Hillestad, James Bigeiow, Anthony Bower, Federico Girosi, Robin Meiii, Richard Scovile, & Roger Taylor
### 1.8.12 Other Project Option to enhance oral health services: Electronic Health Record

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**Related Category 3 Outcome Measure(s):**

- 085144601.3.15
- 3.IT-7.10

**Metric 1** [P-X]: Train faculty, students and staff on certified edition of EHR

**Metric 1 [P-X.1]:** Develop IT training plan and curriculum; train key clinic and IT support personnel.

**Baseline/Goal:** [# of dental/dental hygiene students and residents/faculty & staff trained/Certified EMR

**Data Source:** Training schedules

**Milestone 1 Estimated Incentive Payment:** $169,500

**Milestone 2** [P-X]: Develop quality assurance/quality improvement processes managed with AxiUm EPR

**Metric 1[P-X.1]:** Plan new

**Milestone 4** [P-X]: Train faculty, students and staff on certified edition of EHR

**Metric 2 [P-X.1]:** Add additional features/functionality to EHR system.

**Goal:**

**Track number of faculty, students and staff trained on certified edition of EHR**

**Data Source:** Training schedules; AxiUm (EHR)

**Milestone 4 Estimated Incentive Payment:** $186,132

**Milestone 5** [P-X]: Track the number of quality assurance/quality improvement processes managed with AxiUm EHR.

**Metric 2 [P-X.1]:** Deploy

**Milestone 7** [P-X]: Train faculty, students and staff on certified edition of EHR

**Metric 3 [P-X.1]:** Providers utilizing additionally programmed features on certified EHR system.

**Goal:** 85% compliance

**Data Source:** AxiUm (EHR)

**Milestone 7 Estimated Incentive Payment:** $199,118

**Milestone 8** [I-X]: Track the number of quality assurance/quality improvement processes managed with AxiUm EPR to include Metric 3 [I-X.1]: Utilize the data/information in the quality improvement of patient care. Establish benchmarks to

**Milestone 10** [P-X]: Train faculty, students and staff on certified edition of EHR

**Metric 3: [P-X.1]:** All providers utilizing additionally programmed features on certified EHR system.

**Goal:** 100% compliance

**Data Source:** AxiUm (EHR)

**Milestone 10 Estimated Incentive Payment:** $192,385

**Milestone 11** [I-X]: Track the number of quality assurance/quality improvement processes managed with AxiUm EPR

**Metric 3 [I-X.1]:** Utilize the data/information in patient care improvement. Track # of processes changed, and report on process improvement.

**Data Source:** AxiUm (EHR)

**Milestone 11 Estimated Incentive Payment:** $224,938

### Year 2

(10/1/2012 – 9/30/2013)

- Milestone 1
- Milestone 2

### Year 3

(10/1/2013 – 9/30/2014)

- Milestone 3
- Milestone 4

### Year 4

(10/1/2014 – 9/30/2015)

- Milestone 5
- Milestone 7

### Year 5

(10/1/2015 – 9/30/2016)

- Milestone 8
- Milestone 10

**Goal:** Improve Quality of Care
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Improve IT Quality <strong>Data Source:</strong> Strategic Planning minutes/recommendations. Action plan.</td>
<td><strong>Goal:</strong> Develop patient surveys to be used to monitor behavioral changes and assess patient needs and satisfaction with dental treatment in all clinics <strong>Metric 1</strong> [P-X.1]: Plan for new surveys and desired QA measures; <strong>Goal:</strong> Improve Quality of Care <strong>Data Source:</strong> AxiUm reports: # of surveys utilized, # of clients/computers that access survey</td>
<td><strong>Goal:</strong> Track the number of patient surveys used to monitor behavioral changes for patients and assess patient needs and satisfaction with dental treatment in all clinics <strong>Metric 4:</strong> [I-X.1] Utilize patient surveys in QA process; assess data/address deficiencies in treatment outcomes <strong>Goal:</strong> Improve oral health <strong>Data Source:</strong> AxiUm reports: # of surveys utilized, # of clients/computers that access survey</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong> [P-X]</td>
<td><strong>Milestone 12</strong> [I-X]</td>
</tr>
<tr>
<td>Processes be managed</td>
<td>[P-X] Develop patient surveys to be used to monitor behavioral changes and assess patient needs and satisfaction with dental treatment in all clinics</td>
<td>Track the number of patient surveys used to monitor behavioral changes for patients and assess patient needs and satisfaction with dental treatment in all clinics</td>
</tr>
<tr>
<td>Goal: Improve IT Quality</td>
<td>Goal: Improve Quality of Care – by Tracking improvement processes including patient satisfaction with treatment, treatment outcomes assessments, provider compliance, and making needed changes. <strong>Data Source:</strong> AxiUm (# of reports, forms, queries, additional items added to QA dashboard. # of clients/CPUs that EHR system can be accessed from).</td>
<td>Goal: Improve oral health</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $ 169,500</td>
<td>Milestone 3 Estimated Incentive Payment: $186,132</td>
<td>Milestone 12 Estimated Incentive Payment: $192,385</td>
</tr>
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<td><strong>Milestone 12</strong></td>
</tr>
</tbody>
</table>
clients/ computers that access survey

Milestone 6 Estimated Incentive Payment: $186,132

| Year 2 Estimated Milestone Bundle Amount: $508,500 | Year 3 Estimated Milestone Bundle Amount: $558,396 | Year 4 Estimated Milestone Bundle Amount: $597,354 | Year 5 Estimated Milestone Bundle Amount: $577,154 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,241,404**
Identifying Project and Provider Information:

### Title: 1.7.1 - Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region [Reengineering the Hearing Health Care System in South Texas: A Telehealth Model for Addressing the Unmet Hearing Health Care/Hearing Aid Needs of Adults with Mild to Severe Bilateral Sensorineural Hearing Loss]

**Unique RHP ID#: 085144601.1.15 – PASS 2**

**Performing Provider:** University of Texas Health Science Center at San Antonio

**Performing Provider TPI:** 085144601

### Project Summary:

**Provider Description:**

The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** This project will establish pilot hearing health care delivery model with the goal of making hearing health care services (including hearing aids) more accessible and affordable for those needing it. It will incorporate newly evolving teleaudiology technology placed in existing healthcare location that do not have audiology services; in the context of student training (1.cooperative Doctor of Audiology degree program (UT-Austin/UTHSCSA; and 2. UTHSCSA nursing and other professional degree (e.g. PA, OT) programs and possibly the St. Phillips Alamo College nursing program all participating in a Teleaudiology Clinical Technician course), who will together with mentor audiology faculty learn to deliver teleaudiology services to the target population of adults with self-identified hearing concerns who are not otherwise accessing hearing health care services.

**Need for the project:** It is estimated that 35+ million people in the U.S. have hearing loss significant enough to interfere with communication and quality of life, with only about 24% receiving help for their hearing loss. Accessibility, affordability and effectiveness of hearing health care services (including hearing aids) have been identified as significant factors related to the gap between those needing hearing health care services and those receiving them. As in the rest of the U.S., these issues related to poor utilization of hearing health care are also particularly true in the South Texas region with its vast geographical area, limited hearing health care facilities, and wide educational, health care, and socioeconomic diversity represented among South Texas residents.

**Target population:** Although a significant portion of the adult population with hearing loss are Medicaid and Medicare eligible, hearing health care services delivered via the telehealth modality are not currently reimbursed, with only limited coverage of hearing aids for Medicaid patients and no hearing aid payment coverage for Medicare patients. This pilot project is an effort to show the effectiveness of hearing health care services delivered via the telehealth modality, in terms of triage of patients to the next level of appropriate hearing health care when necessary, and on-site remote teleaudiology delivery of appropriate hearing health care (including hearing aids) for appropriate hard of hearing adult patients (e.g. those with mild to severe hearing loss).
severe bilaterally symmetrical hearing loss, uncomplicated by other medical conditions affecting the auditory system).

**Category 1 or 2 expected patient benefits:** 700 hard of hearing patients (100 in year three; 200 in year four and 400 in year five) will be served via teleaudiology consultation, by 15 Doctor of Audiology students in conjunction with 15-30 nursing students and other professional degree program students participating in the TCT course, working cooperatively under the supervision of audiology faculty in years 2 through 5 of the project.

**Category 3 outcomes:** The goal over years 2-5 of the project is to use teleaudiology to successfully deliver entry-level hearing health care and triage services to 700 patients, and open fit mini behind the ear hearing aids fit with standard earbud coupling to patients for whom they are appropriate and who would, according to the patients, otherwise not have had access to hearing health care and hearing aid services. Patient self-ratings for those using their new hearing aids will be completed regarding their ability to achieve their own goals for improved communication and social function, acceptable hearing aid satisfaction in daily life, and reduction in self-perceived hearing handicap.

**Project Description:**
Establish an innovative pilot South Texas (Bexar County) Hearing Health Care Delivery Model which incorporates existing and new resources including: Teleaudiology; a new level of support personnel (Teleaudiology Clinical Technicians (TCTs); a “Drop-In Hearing Clinic”; community clinic collaborations; and existing partner audiologists, otolaryngologists and Primary Care Providers (MDs/NPs/PAs). This model targets primarily members of the adult hard of hearing population; the majority of whom are not receiving diagnostic/rehabilitative help for their hearing loss. Our ability to communicate using the unique synergies of hearing, speech, voice and language separates humans from the rest of the animal kingdom. It is estimated that 35+ million people in the U.S. have hearing loss significant enough to interfere with communication; 4.6% between 18-44 years; 14% between 45-64 years; 32% over 65 years and 50-50% over 75 years. It is estimated that only 24% are receiving help for their hearing loss; with accessibility, affordability and effectiveness of hearing health care services being significant factors causally related to the gap between those needing hearing health care services and those receiving them. The South Texas Hearing Health Care Delivery Model proposed specifically addresses the challenges of accessibility, cost and effectiveness in the delivery of hearing health care (including hearing aids) to the majority of adults who need it. Specifically, this model proposes the integration of Doctor of Audiology education with the education of other professional students (e.g. nursing students, PA students, etc) who would be completing the new “Teleaudiology Clinical Technician Course”, and the delivery of teleaudiology clinical services via teams of audiologists/TCTs in a “Drop In Hearing Clinic” placed in collaborative partnership in the UTHSCSA Student/Employee Health. This project proposes to coordinate the education of audiologists with that of students in the Teleaudiology Clinical Technician Course to learn to jointly deliver teleaudiology services (hearing/otoscopic screening, hearing aid assessment and dispensing) at a service delivery site (“Drop In Hearing Clinic”) that is located away from the main audiology clinic and more geographically convenient to the target patients, with ability to triage and determine which hearing health care needs can be delivered at the Drop In Clinic versus which needs require referral to the next level of primary or specialty care. Five year expected outcomes for providers include: 15 UT-Austin/UTHSCSA Doctor of Audiology
students will complete clinical rotations among the CECSD hearing/balance consortium partners in the San Antonio region including participation in the Drop-In Teleaudiology Clinic; 15-30 LVN/RN/NP/PA students will complete the Teleaudiology Clinical Technician training course and engage in teleaudiology clinical service delivery in the Drop-In Hearing Clinic. Five year expected outcomes for patients: 700 adult patients will be served at the Drop In Hearing Clinic location and either provided with high performance mini-BTE hearing aids or appropriately referred to the next level of hearing health care.

The objectives (core components) of the project are: 1.7.1 e. to provide patient consultations by audiologists, and ENT specialists as needed, with the assistance of a Teleaudiology Clinical Technicians (a new and necessary category of telehealth support personnel) using telecommunications and digitally-based video otoscopes, audiometers, immittance equipment, real ear probe microphone equipment, and digitally programmable hearing aids that are all remotely controllable by the audiologist with the local assistance of the TCT, and 1.7.1 f. conduct continuous quality improvement by assessing the projects impact and make adjustments as necessary, share best practices and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals: This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Describe PM (Process milestones) and IT (Improvement Targets).

P 1 Conduct needs assessment to identify needed specialties that can be provided via telemedicine.
P 3 Implement telemedicine program for selected medical specialties based upon regional and community need

P10 Review project data and respond with tests of new ideas, practices, tools, solutions.
I18 Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services.

P 1 Providers will engage the stakeholders.
P 2 Establish baseline

IT-10.1 Demonstrate improvement in quality of life (QOL) scores as measured by evidence based and validated assessment tools for quality of life.
Starting Point/Baseline:
UTHSCSA was awarded a University of Texas System grant (STARS) in June 2012 for $1.385 million to support facilities and equipment expansion in support of CECSD program development; including the development of a joint UT-Austin/UTHSCSA collaborative Doctor of Audiology program, a new Teleaudiology Clinical Technician (TCT) certificate program, and collaborative consortium of hearing/balance public/private/VA/DOD partners in the San Antonio region to support the development and delivery of innovative hearing health care programs associated with the CECSD. The DSRIP funding will complete the mosaic of funding to develop the proposed innovative audiology/TCT educational programs and pilot the new hearing health care delivery system model proposed. Baseline 12/1/2011 hearing health care services are currently delivered at a variety of unrelated audiology, hearing aid dispensing, and ENT offices in Bexar county; with hearing aids costing on average $2600/aid, and minimal to no existing third party coverage for them. Hearing aids are a core component of successful hearing loss rehabilitation, and with the current hearing health care delivery model, only those with hearing loss who can find, access and afford hearing health care are getting help for this chronic condition; resulting in failure to “thrive”, loss of productivity, social disengagement, and breakdown in family and social functioning. Currently no clients outside of the VA Hospital System in Bexar County are being served by a tele-hearing health delivery model as the model does not currently exist. There are also very few if any audiologists trained in the delivery of teleaudiology services in the United States, much less the state of Texas and Bexar County, and the category of hearing health care support personnel, Teleaudiology Clinical Technician (TCT), does not exist outside of the VA Health Care System. We also do not currently have a TCT course in place and the joint or cooperative UTHSCSA CECSD component of the UT-Austin Doctor of Audiology program is currently going through the development and approval process at UT-Austin, UTHSCSA, culminating in the creation of the joint or cooperative UT-Austin/UTHSCSA Doctor of Audiology program.

Rationale:
The target goal of this project is to develop a pilot model for a limited scope integrated South Texas Hearing Health Care Network that will enable an optimum continuum of care for patients with hearing/balance and related communication disorders and coordinate the education of audiology students in the UT-Austin/UTHSCSA Doctor of Audiology program with those nurses, PAs or other professional program students, in the new TCT certificate course, with the overall goal of expanding audiology clinical practice to include the delivery of teleaudiology services as proposed in this model. There is great disparity between those with chronic sensorineural hearing loss needing hearing health care services, including hearing aids, and those receiving it in Bexar county and elsewhere in Texas and the U.S. Behavioral Health and Mental Well-Being has been identified as a priority area in the RHP 6 Community Health Improvement Plan for Bexar County. One’s ability to effectively communicate with others through the most natural avenues of hearing and oral speech/language is fundamental to human behavioral and mental health. Research has shown that those with un-rehabilitated hearing loss significant enough to interfere with communication results in symptoms of social withdrawal, social isolation, depression, anxiety, frustration, and paranoia. Individuals who also have significant/debilitating tinnitus for which treatment has not been provided have also been shown to have sleep disorders, family/marital discord, vocational problems, and have even committed suicide because of their inability to cope with their unrelenting tinnitus and hearing loss. Hearing health care services including hearing aids and related adjustment and communication counseling have
been shown to significantly reduce these negative symptoms/behaviors in persons with hearing loss. This project proposes a hearing health care model that would enable more individuals with hearing loss to benefit from appropriate hearing health care intervention, including the use of hearing aids, with the goal of minimizing the contribution of hearing loss as one of the many stressors in the lives of Bexar County citizens participating in this pilot hearing health care system model. This teleaudiology model proposed in this project is made possible by the advent of computer-based hearing test equipment and hearing aids that can be operated remotely via two-way audio/video interactive digital Internet technology. This technology allows audiologists and ENTs to expand their existing practices to include teleaudiology/telehealth delivery of hearing health care, including hearing aids. This means that audiologists/ENTs participating in the South Texas Hearing Health Care Telehealth network could partner with a remote community-based Drop-In Hearing clinic (e.g. UTHSCSA student/employee health clinic) to provide hearing health care to patients being seen at that clinic, without the need to expand their own clinical infrastructure other than the addition of a two-way A/V desk-top video conferencing equipment (e.g. CISCO/Polycom) and their office computer. Via their desk-top video conferencing system, they can then hook-up to the video conferencing system at the Drop-In Hearing Clinic and the digital audiometric equipment (pure tone/speech audiometer, immittance system, video otoscope, real-ear probe microphone equipment and hearing aid programming software) to provide teleaudiology services and patient counseling with the essential support of the on-site TCT. A Hearing Health Care Network consists of audiologists/ENTs in the community who sign on as providers in the Network; enabling them to expand their existing practices and “reach” to locations closer to where the patients live, and enabling patients with hearing loss who would otherwise be un-served due to lack of access to, lack of trust in, and expense of the current hearing health care system, to receive the hearing health care that they need. This proposed innovative South Texas Hearing Health Care System model incorporating telehealth and new ways of providing patient hearing health care has been embraced by the NIH/NIDCD challenge to develop innovative approaches to hearing health care delivery that will demonstrate a model for delivery of hearing health care to underserved populations that is accessible/lower in cost and effective for the majority of adults with hearing loss desiring hearing health care and hearing aids ; NIDCD research on hearing health care (R01): (http://grants.nih.gov/grants/guide/pa-files/PA-100253.html and NIDCD Research on Hearing Health Care (R21/R33): http://grants.nih.gov/grants/guide/rfa-files/RFA-DC-12-003.html Dr. Novak has had initial discussions with NIDCD program officers Dr. Amy Donahue and Dr. Dan Sklare, regarding this proposed model for hearing health care and hearing aid delivery. They have expressed sincere interest in the model and funding of it as a demonstration project in the future.

**Related Category 3 Outcome Measure(s):**

**Category 3 reporting options related to this proposal:**

**OD-10 Quality of Life/Functional Status; IT-10.1 Quality of Life (Standalone measure)**
In general our goal for individuals with hearing loss that is significantly interfering with their ability to communicate and generally enjoy life is to enable them through appropriate assessment and intervention including use of appropriate hearing aids and supportive counseling, to hear more of the sounds around them and better understand speech in a range of situations. Our goal is to help them increase all communication-related activities (World Health Organization). In
short, to more effectively claim their unalienable rights to life, liberty and the pursuit of happiness.

To assess the benefit derived from amplification and the resultant reduction in hearing handicap and improved life quality we will administer three brief questionnaires, prior to intervention (at the time of initial assessment) and following intervention (30-45 days after the initial fitting of amplification and initial communication counseling). Need for programming changes to the hearing aid and further counseling will be determined at the second visit as well. Three standardized self-assessment measures will be used: The Client Oriented Scale of Improvement (COSI); The 10 item Hearing Handicap Inventory for Adults/Elderly Screening Version (HHIE) (Ventry & Weinstein, 1982) which assess both the social and emotional impact of hearing loss on the individual, and the 15 item Satisfaction with Amplification in Daily Life scale (SADL) (Cox and Alexander, 1999), which assess positive effect comprised of decreased communication disability, improved self-confidence, improved sound quality, and overall assessment of worth; service and cost, comprising reliability, clinician competence, and cost; negative features comprised of reaction to background sounds, feedback, and the hearing aid’s usefulness on the telephone; and personal image, comprised of appearance and the apparent reaction of others. Pre and post measures will be taken to assess reduction in hearing handicap and desired increase in communication ability and overall satisfaction and improvement in life quality. Documentation will be maintained to determine those patients are successfully served at the telehealth site, versus those needing referral to the next level of audiology/ENT care at the central site. Documentation will also be maintained to determine number of patients to whom hearing aids are dispensed and who are successfully using them versus those who have returned the aids with assessment of residual reasons for rejection of the hearing aids, after attempts have been made to support successful use, with implications for modifications in the telehealth delivery system as needed.

**Relationship to other Projects:**

1.1 Expand Primary Care: Dr. Julie Cowan Novak

We have identified the UTHSCSA Clinical Enterprise as well as the UTHSCSA School of Nursing as partners in enabling nursing students to develop the technical skills through participation in a Teleaudiology Clinical Technician Certification Course, necessary for them to support the delivery of teleaudiology services in partnership with Doctor of Audiology students in joint UT-Austin/UTHSCSA Doctor of Audiology program. We have also identified the UTHSCSA Student Health and Employee Health site as a location for a pilot Drop-In Hearing Clinic that would serve as both a laboratory for this collaborative/cross-disciplinary student education, as well as a convenient entry point for UTHSCSA students and faculty into the hearing health care delivery system.

**Relationship to Other Performing Providers’ Projects in the RHP:**

There are no other similar projects being proposed

**Plan for Learning Collaborative:**

There are no other similar projects being proposed
Project Valuation:
The value of this project is in its creation of a new model for hearing health care delivery that incorporates both new and existing personnel and new and existing health care facilities in multi-level hearing health care assessment/treatment model designed to address the gross disparity in percentage of adults with hearing loss receiving hearing health care services versus all who need those services. Consistent with the definition of health care “value” as health outcomes per dollar spent, it is designed to provide more convenient patient access to lower cost effective hearing health care resulting in improved hearing/communication ability for an increased percentage of those who need effective hearing health care. The model acknowledges that a significant percentage of this population has sensorineural hearing loss that is essentially bilaterally symmetrical with no other medically-related hearing/balance complications and who primarily need assessment of their hearing and appropriate fitting/adjustment of digital single processing hearing aid technology delivered and supported as close to their neighborhood as possible. A smaller percentage of the adult hard of hearing population needs more extensive audiology and medical services. They are in need of triage from the Drop-In Hearing Clinic with referral to the next level of audiology/medical care. A goal of this project is to demonstrate an approach to the “right care, each time for each patient” for individuals entering the hearing health care system. This triage and referral process would be accomplished through the Drop-In Hearing Clinic access point staffed by remote community audiologists participating in the Drop-In Hearing Clinic Network, working in conjunction with onsite Teleaudiology Clinical Technician whom they supervise. Next-level referrals would be to network audiology/ENT providers who the patients identify as located conveniently to them and/or who has the most immediate ability to schedule a next-level hearing health care appointment for the patient. This would enable the patient to begin the referral relationship facilitated at the Drop-In Hearing Clinic site.

The scope of this pilot project is limited to 2 site: UTHSCSA Student/Employee Health Clinic with audiology faculty and their Au.D. students providing the remote audiology services from the UTHSCSA MARC, University Health Systems Audiology Department; or UT-Austin Department of Communication Sciences and Disorders on-campus audiology clinic in conjunction with UTHSCSA nursing or other professional degree students taking the TCT course. This scope is designed to bring hearing health care services to UTHSCSA students, employees and their families at a central campus location. Project outcomes for providers include: 15 joint UT-Austin/UTHSCSA Doctor of Audiology students will complete clinical rotations among the CECSD hearing/balance consortium partners in the San Antonio region including delivery of audiology services under faculty supervision in the Drop-In Teleaudiology Clinics; 15-30 LVN/RN/NP students will complete the Teleaudiology Clinical Certificate training and engage in teleaudiology clinical service delivery under supervision in the Drop-In Hearing Clinic. Project outcomes for patients: 700 adult patients will be served at the Drop In Hearing Clinic locations and either provided with high performance mini-BTE hearing aids as appropriate or appropriately referred to the next level of hearing health care.
<table>
<thead>
<tr>
<th>085144601.1.15 PASS 2</th>
<th>1.7.1</th>
<th>1.7.1 (E, F)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP</strong></td>
<td><strong>Plan</strong></td>
<td><strong>March 8, 2013</strong></td>
</tr>
<tr>
<td><strong>UTHSCSA</strong></td>
<td><strong>085144601.1.15</strong></td>
<td><strong>P1 – Conduct needs assessment to identify needed specialties that can be provided via telemedicine.</strong></td>
</tr>
<tr>
<td><strong>University of Texas Health Science Center at San Antonio</strong></td>
<td><strong>TPI - 085144601</strong></td>
<td><strong>Conduct needs assessment for development of UTHSCSA teleaudiology focus in current UT-Austin audiology Au.D. program.</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Conduct needs assessment for development of elective teleaudiology clinical certificate course to be offered to nursing and other professional degree (e.g. PA) students and create and deliver the curriculum for Teleaudiology Clinical</strong></td>
</tr>
<tr>
<td><strong>085144601.3.23</strong></td>
<td><strong>3.IT-10.1</strong></td>
<td><strong>Quality of Life</strong></td>
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<td><strong>I-18 – Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services.</strong></td>
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<td><strong>5 students will participate in the 3rd/4th year joint Au.D. program CECSD Consortium clinical rotations/curriculum</strong></td>
<td><strong>Deliver the curriculum for the Teleaudiology Clinical Technician Course and establish it as an elective option for nursing and other professional degree students: 5 to 10 students enrolled</strong></td>
<td><strong>5 students will participate in the 3rd/4th year joint Au.D. program CECSD Consortium clinical rotations/curriculum</strong></td>
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<td><strong>Enhance the curriculum for the Teleaudiology Clinical Technician Certificate and maintain it as an elective option for LVN, BSN, MSN/NP students: 5 to 10 students enrolled</strong></td>
<td><strong>I-18.1Metric: 400 patients will be</strong></td>
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</tbody>
</table>
Technician Course and establish as an elective option for nursing and other professional degree students to be delivered by a combination of face-to-face and telehealth.

Determination of the number of individuals, using questionnaire/survey methods, among those served by student and employee health clinics at UTHSCSA who indicate some degree of hearing handicap (using the Hearing Handicap Inventory for Adults/Elderly-Screening HHIE-S) as a screening questionnaire, who desire help for their hearing loss and are currently not receiving it, who may or may not be currently wearing hearing aids and their current satisfaction with their hearing aids (using the Satisfaction with Amplification in Daily Living (SADL) assessment tool).

Metric[P-1.1]: Completed Needs assessment

Data Source: Compiled completed survey data.

| I.18.1 Metric: Implement teleaudiology service delivery with goal of 100 patients served and appropriate patients provided with high-performance mini-BTE hearing aids at the Drop-In Hearing Clinic with appropriate next-level referrals when needed for all patients served. Advertise availability of the new Drop In Hearing Clinics Goal: 80% of patients provided with open fit mini-BTE digital hearing aids at the Drop in Clinic will keep/use aids successfully Data Source: Drop-In Hearing Clinic Data Base |
|---|---|
| **Milestone 3 Estimated Incentive Payment:** $499,507 |

| I.18.1 Metric: 200 patients will be served and appropriate patients provided with high-performance mini-BTE hearing aids at the Drop-In Hearing Clinic with appropriate next-level referrals. Outcomes will be assessed and interventions modified as indicated to enhance achievement of improved access to and use of teleaudiology services and target patient outcomes of needed hearing health care delivery and hearing handicap reduction. Goal: 80% of patients provided with open-fit mini-BTE digital hearing aids at the Drop in Clinic will keep/use aids successfully Data Source: Drop-In Hearing Clinic Data Base |
|---|---|
| **Milestone 4 Estimated Incentive Payment:** $536,252 |

<p>| I.18.1 Metric: 200 patients will be served and appropriate patients provided with high-performance mini-BTE hearing aids at the Drop-In Hearing Clinics with appropriate next-level referrals. Continue to assess and implement improvements needed to achieve improved access of patients to the teleaudiology services and target patient outcomes of needed hearing health care delivery and hearing handicap reduction. Goal: 80% of patients provided with open-fit mini-BTE digital hearing aids at the Drop in Clinic will keep/use aids successfully Data Source: Drop-In Hearing Clinic Data Base |
|---|---|
| <strong>Milestone 5 Estimated Incentive Payment:</strong> $517,489 |</p>
<table>
<thead>
<tr>
<th>Milestone 1 Estimated Incentive Payment: $227,088</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2</td>
</tr>
<tr>
<td>[P-X]Establish site of service.</td>
</tr>
<tr>
<td>P.X.1 Metric: establish 1 teleaudiology site of service at the UTHSCSA School of Nursing student health/employee health clinic.</td>
</tr>
<tr>
<td>Numerator: 1 established clinic</td>
</tr>
<tr>
<td>Goal: Develop TCT course and coordinated clinical practicum for nursing and other professional degree students in the TCT course with UT-Austin audiology students; develop clinic EMR/billing and Drop-In Hearing Clinic data base system that will support teleaudiology service delivery and data analytics necessary to determine success of patient outcomes.</td>
</tr>
<tr>
<td>Data Source: Department of Otolaryngology: Head and Neck Surgery</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $454,177</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $2,007,425</td>
</tr>
</tbody>
</table>
### Identifying Project and Provider Information:

| Title:  | 1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care |
| Unique RHP ID#: | 085144601.1.16 – PASS 2 |
| Performing Provider: | University of Texas Health Science Center at San Antonio |
| Performing Provider TPI: | 085144601 |

### Project Summary:

**Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** This project is to use telemedicine to provide the specialized cancer-care to underserved areas delivered safely and effectively in their own communities. As a NCI-designated Cancer Center, the CTRC is committed to enhancing access to specialty cancer care in underserved areas.

**Need for the project:** Cancer is a leading public health issue in Texas (It is the number one cause of death for children in Texas age 1-14, and the leading cause of death for people in Texas age 85 or younger). Effective communication is central to quality cancer-care from Primary-Prevention to survivorship (Institute of Medicine Report 1999). In the absence of effective communication, providers of cancer-care are forced to refer patients to tertiary care centers, and the patients and public are forced to travel enormous distances to tertiary-care cancer centers at significant cost to their quality of life and financial health. Communication methods like telemedicine can improve cancer healthcare by enhancing cancer-related decision-making and motivate action to improve the quality of cancer care in underserved areas.

**Target population:** Our target population is the underserved population with or at-risk for cancer in Central and South Texas.

**Category 1 or 2 expected patient benefits:** The CTRC is committed to enhancing Cancer-Telemedicine to communities in underserved areas of South Texas by expanding use of telehealth to provide expert multidisciplinary cancer conferences and Tumor Boards to improve access to evidence-based cancer decision-making across the disease spectrum from prevention to survivorship and end of life care. Increase the percent of providers in underserved areas of South Texas accessing specialty cancer-care consultations by cancer telemedicine by 25% over baseline; and of patients in those areas receiving tertiary cancer-care by telehealth in their own communities by 30 % over baseline by Year-3 of implementation.

**Category 3 outcomes:**

The project seeks to increase the number of patients accessing cancer telemedicine from 60 to 75. Increasing the number of underserved areas from 3 to 5 in DY4 and Increase the number of patients accessing cancer telemedicine from 75 to 100. Increasing the number of underserved areas from 5 to 7 in DY5.
Project Description:
Our goal is to increase access to tertiary-level evidence-based cancer care from primary prevention to survivorship and palliative care in underserved areas of South Texas.

This project is to provide ideal cancer healthcare to underserved areas which is the highest priority for the Cancer Therapy and Research Center (CTRC). As a NCI-designated Cancer Center, the CTRC is committed to enhancing access to specialty cancer care in underserved areas, and to use telemedicine to provide the specialized cancer-care that they need delivered safely and effectively in their own communities. Please see attached table for milestone, metrics, targets. Increase the number of electronic consultations for specialty cancer care without patient being scheduled for an in-person visit, thereby reducing healthcare costs. Reduce wait times for specialty cancer care by expediting tertiary level care.

Finding the ideal time for telemedicine conference to suit the audience; designing just-in-time consultations for cancer prevention and treatment questions; garnering support from local community cancer healthcare providers to access the service; and advertising this service effectively.

With plans to implement cancer-related telemedicine services in Webb (Laredo), Hidalgo (Edinburgh), and Cameron (Brownsville) counties in the initial phase and expand to Val Verde (Del-Rio), Maverick (Carrizo Springs and Eagle Pass), Victoria and Medina (Hondo) Counties in years 3-5, we believe that this project will have a major positive impact on the cancer-related health care in this region.

Region 6 goals:
This project achieves CMS’s Triple aim objectives of assuring that patients receive high quality and patient centered care in the most cost effective way, improving the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, and further developing and maintaining a coordinated care delivery system that improves outcomes while containing costs.

Quality:
To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Starting Point/Baseline:
Cancer is a leading public health issue in Texas (It is the number one cause of death for children in Texas age 1-14, and the leading cause of death for people in Texas age 85 or younger). Effective communication is central to quality cancer-care from Primary-Prevention to survivorship (Institute of Medicine Report 1999). In the absence of effective communication, providers of cancer-care are forced to refer patients to tertiary care centers, and the patients and
public are forced to travel enormous distances to tertiary-care cancer centers at significant cost to their quality of life and financial health. Communication methods like telemedicine can improve cancer healthcare by enhancing cancer-related decision-making and motivate action to improve the quality of cancer care in underserved areas. It is important to use modern communication technology to improve knowledge about, access to, and use of high quality, evidence-based cancer control strategies regardless of race, ethnicity, health status, education, income, age, gender, culture, or geographic region. As a National Cancer Institute-designated Cancer Center, the Cancer Therapy and Research Center (CTRC) is committed to enhancing access to speciality cancer care in underserved areas, and to use telemedicine to provide the specialized cancer-care that they need delivered safely and effectively in their own communities. To this end, the CTRC is committed to enhancing Cancer-Telemedicine to communities in underserved areas of South Texas by expanding use of telehealth to provide expert multidisciplinary cancer conferences and Tumor Boards to improve access to evidence-based cancer decision-making across the disease spectrum from prevention to survivorship and end of life care. Increase the percent of providers in underserved areas of South Texas accessing specialty cancer-care consultations by cancer telemedicine by 25% over baseline; and of patients in those areas receiving tertiary cancer-care by telehealth in their own communities by 30% over baseline by Year-3 of implementation.

### Rationale:

The CTRC is committed to enhancing Cancer-Telemedicine to communities in underserved areas of South Texas by expanding use of telehealth to provide expert multidisciplinary cancer conferences and Tumor Boards to improve access to evidence-based cancer decision-making across the disease spectrum from prevention to survivorship and end of life care. Increase the percent of providers in underserved areas of South Texas accessing specialty cancer-care consultations by cancer telemedicine by 25% over baseline; and of patients in those areas receiving tertiary cancer-care by telehealth in their own communities by 25% over baseline by Year-3 of implementation.

The CTRC has established strong collaborative partnerships to provide cancer telehealth services and virtual Tumor Boards with cancer health providers and communities in Laredo, Harlingen, Edinburgh, with plans to extend services to Del Rio, Eagle Pass, Carizo Springs, Victoria, and Hondo. Video-conferencing using Webex communication has been successfully tested for links to Laredo and Harlingen. Dr. Karnad has made trips to Harlingen and to Laredo with CTRC teams to establish cancer telemedicine conferences and tumor boards in formats most acceptable to the communities served, and highlighting specific cancer types common in those communities (hepatocellular carcinoma) or for expert consultation on uncommon cancers (leukemia and hematological cancers).

This project addresses the following community needs:

- CN.2, a high prevalence of chronic disease and related health disparities requiring greater prevention efforts and improved management of patients with chronic conditions. Cancer is a leading cause of death in RHP 6.
- CN.1, the need for improved health care quality in our community.
- CN.3, the need for improved access to medical care due to health care provider shortages.

There are no projects funded by the US Department of Health and Human Services serving a similar purpose as the project being submitted.
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure:</th>
<th>OD 9 Right Care, Right Setting IT-9.4 Other Outcome Improvement Target. Percentage increase the number of patients accessing cancer telemedicine services.</th>
</tr>
</thead>
</table>

1. Health Disparities: 1. Cancer is the leading cause of death among Hispanics in the US—the largest and fastest growing minority group in the US. It is therefore a priority for this RHP to serve 20% of all Hispanics in the US residing in Texas who potentially face cancer health disparity. It is essential to note that 1 in 2 Hispanic men, and 1 in 3 Hispanic women will be diagnosed with cancer, and the lifetime probability of dying from cancer is 1 in 5 for Hispanic men and 1 in 6 for Hispanic women.

2. Disparity between rural and urban cancer-survival can be improved by telemedicine efforts to enhance delivery of ideal care to populations at risk: Sabesan S, et al., Rural Remote Health. 2009 Jul-Sep;9(3):1146.

3. The delivery of complex cancer-care in the patient’s own communities instead of their having to travel to tertiary-care centers will result in significant improvement in quality of life, and eliminate delays between diagnosis and treatment leading to improvement in survival.

### Relationship to other Projects:

This project is related to 4 other projects under the plans to “Introduce, Expand, or Enhance Telemedicine/Telehealth. Three of these are hospital based in Bexar County: University Health System, Christus Santa Rosa, and Methodist Hospital Systems. The other, like our project is at UTHSCSA.

### Relationship to Other Performing Providers’ Projects in the RHP:

While a list of the other provider names is not available at this time, we would be able to immediately implement a learning collaborative to support this project and share best practices since all the other 4 projects are in our Medical Center Campus.

### Plan for Learning Collaborative:

Our project focuses on cancer as a primary disease category in our area. We would establish a learning collaborative meeting that is regularly scheduled, perhaps also conducted via teleconference, and identify shared goals even though the focus of the other projects will be a different category of illness, or target group: identifying stakeholders for areas served; telemedicine/telehealth program content; Information technology costs and implementation; and ideal outcome measure evaluation systems.

### Project Valuation:

Cancer is a huge burden in Texas and it is important to point out that Cancer is the leading cause of death among Hispanics in the US—the largest and fastest growing minority group in the US. With 20% of all Hispanics in the US residing in Texas, we will need to prepare for 1 in 2 Hispanic men, and 1 in 3 Hispanic women being diagnosed with cancer, and the lifetime probability of dying from cancer is 1 in 5 for Hispanic men and 1 in 6 for Hispanic women (American Cancer Society, Cancer Facts and Figures for Hispanics and Latinos 2012-2014), we will need to enhance the access to specialty cancer-care using telemedicine and for this...
population. In addition, there are projected to be nearly 12 million cancer survivors by 2020, >60% of whom are age >65—it is critical, therefore, to use the best technology to provide immediate access to specialty cancer-care across all areas of Texas urban and rural using telemedicine to deal with this magnitude of elderly cancer survivors who will need care, surveillance, and efforts to promote healthy aging (Parry C et al., Cancer Epidemiol Biomarkers Prev 2011;20:1996-2005).

There is a disproportionately higher incidence of the following cancers in South Texas: cervical cancer (11.5/100,000), liver and gall bladder cancer (10.4/100,000), stomach cancer (8.6/100,000) and childhood leukemia (47/million). This project will serve the needs of these high-incidence cancers in addition to all other types.
<table>
<thead>
<tr>
<th>085144601.1.16 PASS 2</th>
<th>1.7.2</th>
<th>NA</th>
<th>1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.24</td>
<td>3.1T-9.4</td>
<td>Other outcome improvement target</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt;[P-X]: Implement cancer telemedicine conferences to underserved communities &lt;br&gt;Statistics from Texas Department of State Health Services “Expected number of cancer cases and deaths, Texas, 2012”&lt;br&gt;Year 1&lt;br&gt;Numerator: # of patients per year with newly diagnosed cancer receiving telehealth services = 0&lt;br&gt;Denominator: # of patients per year with newly diagnosed cancer = 4845&lt;br&gt;Year 2 (planning stage)&lt;br&gt;Numerator: 0&lt;br&gt;Denominator: 0&lt;br&gt;Metric 1 [P-X.1]: a) Telemedicine conference</td>
<td><strong>Milestone 3</strong>&lt;br&gt;[P-X]: Increase the number of patients accessing cancer telemedicine services&lt;br&gt;Numerator: 60&lt;br&gt;Denominator: 4845&lt;br&gt;Benchmark/Goals&lt;br&gt;Numerator: Number of sites meeting goal: 1&lt;br&gt;Denominator: Number of sites participating: 3&lt;br&gt;Metric 1 [P-X.1]: Number of unique cancer-related patients presented for discussion via Webex teleconferences at the CTRC.&lt;br&gt;Numerator: Number of patients referred to oncology specialties electronically that have their referral resolved via Webex.&lt;br&gt;Denominator: Number of</td>
<td><strong>Milestone 4</strong>&lt;br&gt;[P-X]: Increase the number of patients accessing cancer telemedicine services&lt;br&gt;Numerator: 100&lt;br&gt;Denominator: 4845&lt;br&gt;Benchmark/Goals&lt;br&gt;Numerator: Number of sites meeting goal: 2&lt;br&gt;Denominator: Number of sites participating: 4&lt;br&gt;Metric 1 [P-X.1]: Number of unique cancer-related patients presented for discussion via Webex teleconferences at the CTRC.&lt;br&gt;Numerator: Number of patients referred to oncology specialties electronically that have their referral resolved via Webex.&lt;br&gt;Denominator: Number of</td>
<td><strong>Milestone 5</strong>&lt;br&gt;[I-18]. Improvements in access to specialist care of patients receiving telemedicine/telehealth services using innovative project option.&lt;br&gt;[I-18.1] Metric: Target population reached through telemedicine/telehealth program&lt;br&gt;Numerator: 200&lt;br&gt;Denominator: 4845&lt;br&gt;Benchmark/Goals&lt;br&gt;Numerator: Number of sites meeting goal: 4&lt;br&gt;Denominator: Number of sites participating: 6&lt;br&gt;c. Data Source: Documentation of target population reached, as designated in the project plan (please see Rationale on page 2 for target communities).</td>
</tr>
<tr>
<td>Infrastructure in place and functional</td>
<td>Denominator: Number of patients referred to oncology specialties.</td>
<td>patients referred to oncology specialties.</td>
<td>Milestone 5 Estimated Incentive Payment: $776,234</td>
</tr>
<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>b) Data Source: CTRC</td>
<td>Data Source: Patient records from electronic referral processing system</td>
<td>Data Source: Patient records from electronic referral processing system</td>
<td>d. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching its targeted population.</td>
</tr>
<tr>
<td>telemedicine conference sign in sheets, conference summaries with HIPAA protected patient information</td>
<td>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 oncology specialist</td>
<td>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 oncology specialist</td>
<td>Milestone 5 Estimated Incentive Payment: $776,234</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>[P-X]: Develop and quantify baseline for those accessing telemedicine services.</td>
<td>Metric 1 [P-X.1]</td>
<td></td>
</tr>
<tr>
<td>[P-X]: Develop and quantify baseline for those accessing telemedicine services.</td>
<td>a) Number of unique cancer patients presented for discussion via Webex teleconferences at the CTRC</td>
<td>a) Number of unique cancer patients presented for discussion via Webex teleconferences at the CTRC</td>
<td></td>
</tr>
<tr>
<td>b) Data Source: CTRC telemedicine conference sign in sheets, conference summaries with HIPAA protected patient information</td>
<td>b) Data Source: CTRC telemedicine conference sign in sheets, conference summaries with HIPAA protected patient information</td>
<td>b) Data Source: CTRC telemedicine conference sign in sheets, conference summaries with HIPAA protected patient information</td>
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</table>

| Year 2 Estimated Milestone Bundle Amount: $681,266 | Year 3 Estimated Milestone Bundle Amount: $749,261 | Year 4 Estimated Milestone Bundle Amount: $804,379 | Year 5 Estimated Milestone Bundle Amount: $776,234 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,011,140
Identifying Project and Provider Information:

Title: 1.9.3 Implement other evidence based project to expand specialty care capacity in an innovative manner - Oncology
Unique RHP ID#: 085144601.1.17 – PASS 2
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Project Summary:

Provider Description:

The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): The project is to increase trained oncology providers to serve the cancer population in Central and South Texas.

Need for the project: There is an overwhelming burden of cancer affecting our population in Texas—cancer is the leading cause of death in this state, coupled with serious shortage of trained oncology providers—Texas ranks 45th in the nation in the number of physicians per population: Therefore, we would like to educate the next generation of cancer care providers especially medical oncologists who can provide ideal cancer care from cancer prevention to survivorship care in rural and underserved areas of South Texas.

Target population: Our target population is the underserved population with or at-risk for cancer in Central and South Texas.

Category 1 or 2 expected patient benefits: The project seeks to increase the number of fellows in the ACGME accredited program by 25% per year over baseline

Category 3 outcomes:

The project seeks to increase the number of fellows serving in outreach clinics in underserved areas from 2 to 4 in DY4 and from 4 to 6 in DY5. It also seeks to serve 3 to 5 clinics in DY4 and 5 to 7 in DY 5

Project Description:

The aim of the project is to train new oncologists to enhance delivery of cancer care in underserved areas of South Texas.

The United States will likely face a major (36%) deficit in the number of oncologists relative to the demand for cancer care by the year 2020. This is in large part due to dramatic increases in cancer survivorship, and the projected 48% increase in cancer incidence caused by the aging population. Thus, there is likely to be a shortfall of between 2,550 and 4,080 oncologists by the year 2020. In Texas, cancer is the leading cause of death for those aged 85 and younger, and this year 110,135 Texans will be diagnosed with cancer and 39,072 will die of the disease. It is
estimated that there were 457,076 cancer survivors in Texas diagnosed between 1998 and 2007. The estimated cost of cancer care in Texas for 2010 was $25.3 billion. Texas ranks second in total population, but 45th in the nation in the number of physicians per population. Graduate Medical Education (GME) refers to the specialized training a physician receives after graduating from medical school, and specialty training in Oncology is obtained through completion of a residency program in that specialty. Texas has fewer GME slots than New York, California, or Pennsylvania. Training new oncologists is therefore critical to delivering ideal cancer care in South Texas in the future, especially with training in cancer health disparities and practice in outreach clinics in underserved areas. The fellowship training program in hematology and medical oncology at the UT Health Science Center, San Antonio, is fully accredited by the Association for Graduate Medical Education (ACGME) and currently has a three-year program which graduates 4 new oncologists per year. The Supreme Court’s decision to uphold the individual mandate in the Affordable Care Act (ACA) means 32 million newly insured Americans will be entering the health care system. This makes addressing the nation’s physician shortage—projected to climb to more than 90,000 by 2020—more important than ever. Additional residency slots and increased funding for doctor training will ensure that Americans have access to care, not just an insurance card. The training of new oncologists with special skills to practice in Texas will lead to quality cancer care provided to cancer patients, including those in active treatment, those facing a terminal illness, and for cancer survivors.

Our training program provides large amounts of indigent care. Funding for the existing approved training slots is threatened by a lack of stable state-supported GME funding through the state Medicaid Program (Texas is one of only three states in the country that does not provide GME funding through the state Medicaid program). Lack of sustained funding for oncology training may force a reduction in the number of slots for trainees at a time of desperate need to increase the training pipeline for new oncologists.

**Patient Benefit and 5 year expected outcome:**

The total number of new patients with cancer per year in Webb, Hidalgo, and Cameron Counties is estimated to be about 4,000. Conservative estimates indicate that about 30% (1,200) will be either Medicaid eligible, or considered indigent. The proposed project would provide outreach clinics staffed by fellows with supervision from Faculty to serve this population. The number of oncology clinics to be staffed in underserved areas, targeting this population, will grow from 2 in DY 4 to 6 in DY 5.

The number of Medicaid and Indigent patients that will receive cancer treatment/services within an outreach setting as a result of instituting this project by DY year is as follows:

- **DY 3:** 60 cancer patients (5% of total projected Medicaid/Indigent patients)
- **DY 4:** 120 cancer patients (10% of total projected Medicaid/Indigent patients)
- **DY 5:** 300 cancer patients (25% of total projected Medicaid/Indigent patients)

Uninsured estimated data from South Texas Health Status Review by Ramirez et al.
Region 6 Goals:

This project achieves CMS’s Triple aim objectives of assuring that patients receive high quality and patient centered care in the most cost effective way, improving the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, and further developing and maintaining a coordinated care delivery system that improves outcomes while containing costs.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Starting Point/Baseline:

Texas Medical Association (TMA) data show that physicians who complete both medical school and GME in the state are almost three times more likely to practice in Texas. Our own data on training oncologists from 2004-2012 in our ACGME accredited training program at the UT Health Science Center demonstrates the following: 19 of the total of 26 (73%) oncologists who graduated from our program in this period stayed in Texas upon graduating, and of those, 17 (89%) are still practicing in Texas.

Rationale:

The main reason for selecting this project is: educating the next generation of cancer care providers especially medical oncologists who can provide ideal cancer care from cancer prevention to survivorship care in rural and underserved areas of South Texas is one of the highest priorities for the NCI-designated Cancer Center, the CTRC. We would like to increase the capacity to provide cancer care and oncology specialty care services and the availability of highly trained specialty providers to better accommodate the high demand for cancer care and oncology specialty care so that patients have efficient and effective access to such services in their own community.

This project addresses the following community needs:

- CN.2, a high prevalence of chronic disease and related health disparities requiring greater prevention efforts and improved management of patients with chronic conditions. Cancer is a leading cause of death in RHP 6.
- CN.1, the need for improved health care quality in our community.
- CN.3, the need for improved access to medical care due to health care provider shortages.

There are no projects funded by the US Department of Health and Human Services serving a similar purpose as the project being submitted.
Related Category 3 Outcome Measure(s):

Related Category 3 Outcome Measure:
OD-11 Addressing Health Disparities in Minority Populations
IT-9.4 Other Outcome Improvement Target. Percentage increase the number of new oncology trainees.

In Texas, cancer is the leading cause of death for those aged 85 and younger, and this year 110,135 Texans will be diagnosed with cancer and 39,072 will die of the disease. It is estimated that there were 457,076 cancer survivors in Texas diagnosed between 1998 and 2007. The estimated cost of cancer care in Texas for 2010 was $25.3 billion. Texas ranks second in total population, but 45th in the nation in the number of physicians per population. Graduate Medical Education (GME) refers to the specialized training a physician receives after graduating from medical school, and specialty training in Oncology is obtained through completion of a residency program in that specialty. Texas has fewer GME slots than New York, California, or Pennsylvania. Training new oncologists is therefore critical to delivering ideal cancer care in South Texas in the future, especially with training in cancer health disparities and practice in outreach clinics in underserved areas.

The American Society of Clinical Oncology and other national organizations have published data on manpower shortage in oncology and these data can be accessed in:

a) A report to the American Society of Clinical Oncology (ASCO) from the AAMC Center for Workforce Studies. March 2007; 1-130.
c) Center for Workforce Studies. AAMC. Recent Studies and Reports on Physician Shortage in the US. August 2011 p1-21

Training oncology providers who will have expertise in delivering complex cancer prevention and treatment efforts in outreach clinics, and rural communities that are underserved will clearly improve the health of low-income populations who will have enhanced access to care in their own community.

Relationship to other Projects:
This project is related to 15 other projects under the plans to “Expand Specialty Care Capacity.”. 11 of these are hospital systems; 5 based in Bexar County; 3 based in Rural Communities; and. 4 others, like our project are at UTHSCSA.

Relationship to Other Performing Providers’ Projects in the RHP:
Projects at Bexar County Hospital Systems include: University Health System, Baptist, Childrens, Methodist, and Southwest General. Rural Providers include Dimmit County, Val Verde, and Connally. In addition, there are 4 others on campus at UTHSCSA. We would be able to immediately implement a learning collaborative to support this project and share best practices with many of the above providers especially if they are closely related to expanding specialty care capacity as it relates to training new providers.
**Plan for Learning Collaborative:**

Our project focuses on training oncology providers to provide and expand cancer-care in at-risk communities in rural areas and other communities. We would establish a learning collaborative meeting that is regularly scheduled, perhaps also conducted via teleconference, and identify shared goals, especially if projects are related to training programs to enhance the workforce, even though the focus of the other projects will be a different category of illness, or target group: identifying stakeholders for areas served; telemedicine/telehealth program content; Information technology costs and implementation; and ideal outcome measure evaluation systems.

**Project Valuation:**

Cancer is a huge burden in Texas and it is important to point out that Cancer is the leading cause of death among Hispanics in the US—the largest and fastest growing minority group in the US. With 20% of all Hispanics in the US residing in Texas, we will need to prepare for 1 in 2 Hispanic men, and 1 in 3 Hispanic women being diagnosed with cancer, and the lifetime probability of dying from cancer is 1 in 5 for Hispanic men and 1 in 6 for Hispanic women (American Cancer Society, Cancer Facts and Figures for Hispanics and Latinos 2012-2014), we will need to enhance the number and quality of trained oncologists to serve this population. In addition, there are projected to be nearly 12 million cancer survivors by 2020, >60% of whom are age >65—it is critical, therefore, to prepare a workforce to deal with this magnitude of elderly cancer survivors who will need care, surveillance, and efforts to promote healthy aging (Parry C et al., Cancer Epidemiol Biomarkers Prev 2011;20:1996-2005).

There will be a 48% increase in new cases of cancer, and an 81% increase in people living with or surviving cancer between 2000 and 2020. Visits to oncologists are expected to increase by 48% by 2020, the projected supply of oncologists will leave a shortfall of 9.4 to 15.1 million visits. This project aims to correct the shortfall by increasing the workforce of cancer doctors in South Texas.
<table>
<thead>
<tr>
<th>085144601.1.17</th>
<th>1.9.3</th>
<th>N/A</th>
<th>1.9.3 Implement other evidence based project to expand specialty care capacity in an innovative manner - Oncology</th>
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<tbody>
<tr>
<td>PASS 2</td>
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<td>University of Texas Health Science Center at San Antonio</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.25</td>
<td>3.IT-9.4</td>
<td>IT-9.4 Other Outcome Improvement Target.</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P-X] Create infrastructure to collect data on the graduates of our oncology fellowship training who practice in Texas. <strong>Metric 1 [P-X.1] a)</strong> Demographics and practice patterns on graduates of our oncology training program with statistics on service in underserved areas of South Texas. <strong>b)</strong> Data Source: Graduate medical education database for tracking demographics and practice patterns</td>
<td>Milestone 3 [P-X] Increase the number of new oncology trainees by 20% over baseline. <strong>Metric [P-X.1]:</strong> New oncology trainees. (Dependent on baseline). Numerator: Total number of oncology trainees Denominator: Baseline count of oncology trainees. <strong>Data Source:</strong> GME Enrollment records.</td>
<td>Milestone 5 [P-X] Increase the number of new oncology trainees by 25% over baseline. <strong>Metric [P-X.1]:</strong> New oncology trainees (Dependent on baseline). Numerator: Total number of oncology trainees Denominator: Baseline count of oncology trainees. <strong>Data Source:</strong> GME Enrollment records.</td>
<td>Milestone 7 [I-X] Provide services/treatment to 300 total patients in outreach clinics. <strong>Metric [I-X.1]:</strong> Number of new patients receiving treatment in outreach clinics. Goal: 300 total patients Milestone 7 Estimated Incentive Payment: $517,489</td>
</tr>
</tbody>
</table>

Milestone 1 Estimated Incentive Payment: $227,088

Milestone 3 Estimated Incentive Payment: $249,753

Milestone 5 Estimated Incentive Payment: $268,126

Milestone 7 Estimated Incentive Payment: $517,489
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<thead>
<tr>
<th>Metric [P-X.1]: Establish a baseline count of South Texas oncology trainees</th>
<th>Metric [I-X.1] Number of new patients receiving treatment in outreach clinics:</th>
<th>patients receiving treatment in outreach clinics:</th>
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<tr>
<td>Data Source: GM E enrollment statistics.</td>
<td>Goal: 60 new patients</td>
<td>Goal: 120 patients total patients</td>
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<td>Data Source: Medical Records and charts.</td>
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<tr>
<td>Milestone 4 Estimated Incentive Payment: $249,753</td>
<td>Milestone 6 Estimated Incentive Payment: $268,126</td>
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| Year 2 Estimated Milestone Bundle Amount: $454,177 | Year 3 Estimated Milestone Bundle Amount: $499,507 | Year 4 Estimated Milestone Bundle Amount: $536,252 | Year 5 Estimated Milestone Bundle Amount: $517,489 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,007,425**
Identifying Project and Provider Information:
Title: 1.9.2 Improve Access to Specialty Care (Pediatric Specialty Care Network)
Unique RHP ID#: 085144601.1.18 – PASS 2
Performing Provider: The University of Texas Health Science Center at San Antonio; Pediatric Cardiology, Pediatric Hematology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Neurology, Pediatric Pulmonology
Performing Provider TPI: 085144601

Project Summary:
Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and a 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): This project will establish three pediatric specialty care clinics throughout greater San Antonio to improve access to pediatric specialists for children and families. The proposed new clinics are expected to be located in central San Antonio, south or southeast San Antonio, and north central San Antonio.

Need for the project: A recent study documented the current shortage of pediatric subspecialists in Bexar County, and projected an expanding need for additional pediatric subspecialists through the end of this decade. Additionally, the great majority of subspecialty providers are based in the South Texas Medical Center (northwest), creating an additional access barrier to patients and families. In particular, this access barrier is most acute for patients who are indigent.

Target population: The target population is children in greater San Antonio requiring outpatient pediatric cardiology, pediatric dermatology, pediatric endocrinology, pediatric gastroenterology, pediatric neurology, and pediatric pulmonology evaluation. Over 50% of children in RHP6 have Medicaid or are indigent and we anticipate this project will have Medicaid representation of 60% or more of total estimated patient visit volume. We expect all children, including those with Medicaid, to benefit from clinical expansion and improved access. The proposed clinic sites are located throughout greater San Antonio to minimize the effects of travel and access. In particular, the specialty clinic sites in downtown San Antonio and southeast San Antonio have been chosen specifically because central San Antonio, west San Antonio, and south San Antonio have a preponderance of Medicaid-eligible and indigent children. These locations will greatly enhance the access to care for these vulnerable populations.

UT-Medicine challenges related to this project
UT-Medicine, one of the major employers of pediatric specialists and subspecialists in San Antonio does not have adequate long-term outpatient capacity for specialty care pediatrics. With the construction of the new academic children’s hospital, planned for the South Texas Medical Center, the space available for specialty pediatrics will be expanded, but not until 2016. UT-Medicine is committed to the belief that much of pediatric specialty care can be delivered in community sites more convenient to patients and families than the Medical Center. This project will allow creation of satellite sites that are more convenient to the majority of the communities in greater San Antonio.
**Category 1 or 2 expected patient benefits:** This project seeks to provide 11,000 pediatric specialty care visits in DY3, 19,000 specialty care visits in DY4, and 24,000 specialty care visits in DY5. Additionally, this project seeks to improve access by establishing an electronic referral program.

**Category 3 outcomes:** This project will monitor patient satisfaction throughout the process of clinic establishment and will aim to continually improve patient satisfaction scores through education of staff and providers, improvement efforts, and a learning collaborative design to spread successes in patient satisfaction.

**Project Description:**

UT-Medicine has the opportunity to improve access to Pediatric Specialists through the addition of a group of multi-specialty, multi-site pediatric subspecialty clinics. This will be a part of a network of pediatric care, partnering with a new academic children's hospital delivering a comprehensive network of services. This initiative supports enhanced delivery of subspecialty pediatric services. It is expected that the new academic children’s hospital will be located in or adjacent to the South Texas Medical Center, in northwest San Antonio. By establishing alternate ambulatory specialty pediatric clinic access points throughout San Antonio, we propose to provide improved access through geographically convenient sites, and improved access by increasing the total number of available providers and total number of appointment slots available.

Delivery of pediatric specialty care will be enhanced through these improvements:
1. Establishment of a network of pediatric specialty care clinics staffed by specialists in pediatric cardiology, pediatric neurology, pediatric gastroenterology, pediatric hematology, and pediatric pulmonology and pediatric endocrinology. Eventually, there will be a central hub clinic adjacent to the academic children's hospital, and there will be three satellite clinics in Bexar county.
2. The satellite clinics will be supported and managed through the use of a multifunctional Electronic Medical Record that will allow electronic referrals to the clinics and will allow timely, reliable, and durable communication to referring physicians and practitioners. Additionally, the use of a common EMR for all sites and all providers will eliminate common process variation, enhancing delivery of service.
3. Additional subspecialty providers will be recruited to support this service expansion.

**Quality:**
To achieve continuous quality improvement we will assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**RHP 6 goals:**
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.
**Starting Point/Baseline:**

A recent study, commissioned by the Methodist Healthcare Ministries, established that Bexar County currently lacks at least 20 pediatric subspecialists compared to the number of providers usually expected to provide reasonable access to care for children with specialty care needs. Additionally, the complement of pediatric specialists is aging with 2/3 of the current complement between the ages of 45 and 65 years. By the end of the decade, the number of children in Bexar County is projected to increase by at least 100,000. With this projected growth, and the expectation that providers will leave through retirement or relocation, it is expected that there is a need for an additional 75 to 95 pediatric subspecialists to join the medical community in San Antonio by the end of the decade to meet the needs of our children.

Currently, the greatest concentration of specialty care provider clinics in RHP6 bases in the South Texas Medical Center. This requires families with specialty care concerns to travel to the providers, creating access barriers. There are insufficient numbers of pediatric subspecialists in the community to address subspecialty care needs of infants, children and young adults.

Currently, in UT-Medicine, only the cardiology division provides subspecialty access outside downtown and the medical center, by providing regular outpatient clinics in north central San Antonio, New Braunfels, Seguin, and Jourdanton.

This project will be marked by multiple starting points, relevant to the three project interventions:

- Venues for pediatric specialty care will be established in downtown San Antonio, north central San Antonio, and southeast San Antonio. These sites will be established sequentially as additional providers are successfully recruited.
- UT-Medicine currently uses Epic as their EMR, but it has not yet been deployed throughout the practice. Epic training will occur for all providers and support staff that will be a part of the specialty care expansion. Epic will be deployed for use in each specialty care clinic as they are opened.
- UTHSCSA approval for additional faculty in pediatric cardiology, pediatric pulmonology, pediatric gastroenterology, pediatric neurology, pediatric endocrinology, and hematology will be secured. Recruitment will proceed for these new providers to allow adequate staffing of all subspecialty clinic sites.

**Patient Benefit:**

The number of pediatric visits to be generated by expansion of sub-specialty pediatric services as described within this project are as follows by DY Year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits</th>
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<tr>
<td>DY 3</td>
<td>11,000</td>
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<tr>
<td>DY 4</td>
<td>19,000</td>
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<tr>
<td>DY 5</td>
<td>24,000</td>
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</table>

Of the visits listed above UTHSCSA estimates at least 60% of those visits will be delivered to Medicaid and Indigent patients.
Rationale:
As related above, Bexar County and RHP 6 have a significant current shortage of pediatric specialty care providers and this shortage is predicted to become a critical shortage by the end of the decade. Partly related to this shortage of providers, there are few locations where children can access pediatric specialty care. The current systems of access and communication are limited by old models of communication which can be enhanced with adoption of novel electronic methods.
These improvements will help to:
1.9.2: Improve access to specialty care. This proposal will increase the total number of pediatric specialty providers in the community and will expand the number of locations in the greater San Antonio area that families can access pediatric specialty care. Establishing a network of specialty clinics throughout the metropolitan area increases the number of available appointments and creates more convenient locations for care. Implementing EpicCare and enrolling practitioners in EpicCare will establish and enhance processes for effective coordination and integration of care for our patients within our practice and with other partners.

Proposed Milestones:
Milestone 1 (P-1: Conduct specialty care gap analysis based on community need):
Milestone 2 (P-3: Develop baseline data for wait times, back log, and or return appointments).
Milestone 3 (P-11: Launch/expand a specialty care clinic: Goal: Add Pediatric Specialty Clinic Site in Southeast San Antonio)
Milestone 4 (P-8: Develop the technical capabilities to facilitate electronic referral.)
Milestone 5 (I-33]: Increased number of specialty care visits: Goal: A total of 11,000 patients will be seen in the specialty clinics)
Milestone 6 (I-24: Implement specialty care access programs, e.g., referral technologies, Goal: 20% of the referring providers will be enrolled in EpicCare.)
Milestone 7 (P-11: Launch/expand a specialty care clinic: Goal: Add Pediatric Specialty Clinic Site in North Central San Antonio)
Milestone 8 (P-8: Develop the technical capabilities to facilitate electronic referral. Goal: EpicCare will be implemented in the new Pediatric Specialty Clinic.)
Milestone 9 (I-33: Increased number of specialty care visits: Goal: A total of 19,000 patients will be seen in the specialty clinics)
Milestone 10(I-24: Implement specialty care access programs, e.g., referral technologies. Goal: 30% of referring providers will be enrolled in EpicCare.)
Milestone 11 (P-11: Launch/expand a specialty care clinic: Goal: Add Pediatric Specialty Clinic Site in Southeast San Antonio)
Milestone 12 (P-8: Develop the technical capabilities to facilitate electronic referral. Goal: EpicCare will be implemented in the new Pediatric Specialty Clinic.)
Milestone 13 (I-33: Increased number of specialty care visits. Goal: A total of 24,000 patients will be seen in the specialty clinics)

Core project components:
  a) Increase service availability with extended hours.
In the initial phases of this project, we anticipate that the specialty clinics will operate during standard hours (8AM to 5PM.) However, if there is an identified
need for further expansion of activities, this will be considered through our quality improvement process. In particular, after establishment of all three clinic sites, this will be evaluated as a potential opportunity for further expansion in DY-5.

b) Increase number of specialty clinic locations.

Three new unique pediatric specialty clinic locations will be established in this project. The three clinics are distributed throughout greater San Antonio, with geographic sensitivity, and avoiding the South Texas Medical Center. By design, the downtown pediatric specialty clinic and the southeast specialty clinic are placed in areas of greater community need due to a preponderance of Medicaid-eligible and indigent patients and families.

c) Implement transparent, standardized referrals throughout the system

We plan to use deploy an electronic referral system based in EpicCare. This will increase the ways that referrals can be processed, augmenting entry into the system, and allowing direct feedback to providers in a timely fashion.

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

Information about service delivery will be collected through the use of the Agency for Healthcare Research and Quality tool “CAHPS Clinician & Groups Surveys – Visit Survey 2.0 (Child)”. This information will allow us to determine if we are delivering care in such a way that it is valuable and meaningful to the patients and families. All shortcomings that are identified with this tool will become targets for improvement. Formal quality improvement tools will be used to determine best steps for improvement. Differences in meeting the needs of indigent and Medicaid-eligible populations will be surveyed, and if the needs are found to be different in different locations, unique delivery interventions will be tested. The results of rapid cycle improvement tactics will be determined through ongoing use of the CAHPS tool. Successful interventions will be shared throughout the pediatric specialty clinic operations. Additional opportunities for further dissemination will be sought through presentations and publications.

CN.3 This project addresses the RHP 6 need of expanding access to medical care.

**Related Category 3 Outcome Measure(s):**

**OD-6: Patient Satisfaction.** IT 6.1 Patient satisfaction will be measured throughout the process of subspecialty clinic expansion and operation. Baseline data will be collected from a sample of patients in each specialty area in DY2. The survey tool used will be designed on the survey framework provided in the Agency for Healthcare Research and Quality tool “CAHPS Clinician & Groups Surveys – Visit Survey 2.0 (Child).”

Key survey elements will include:

A) Patient/parent impression of ease of access to specialist and timeliness of appointment

B) Patient/parent impression of the quality of physician communication.

C) Patient/parent impression of involvement in shared decision making.
The information collected through the survey process will be reviewed continually throughout the process (DY2 through DY5.) Quarterly feedback will be given to providers (physicians and nurse practitioners) in the specialty care clinics and to the clinic leadership. Individual specialty clinic sites will be empowered to adopt changes to improve patient satisfaction. Successful improvements will be shared formally throughout the Specialty Care network semi-annually through a Learning Collaborative model. This activity will accomplish the following Process Milestones:

P-1: Project planning. Information collected at baseline in DY2 and DY3 will be used to identify specific targets for improvement in the processes of new patient referral, appointments, communication, and decision making. This will allow planning for general improvements in access, and allow design of educational efforts to assure that patient satisfaction improves throughout the process. The new specialty clinics will not begin to be established until the end of DY2. Initial patient satisfaction data will be collected from existing UT-Medicine clinics in pediatric cardiology, pediatric hematology, pediatric endocrinology, pediatric gastroenterology, pediatric neurology, and pediatric pulmonology prior to opening new specialty clinics.

P-2: Establish baseline rates: This activity will establish specific baseline rates for patient satisfaction and will be used to identify practitioners and services with high baseline outcomes to guide improvements throughout the Pediatric Specialty Care Network.

P-3: Develop and test data systems. The initial survey tool will be modeled closely upon the CAHPS Clinician & Groups Survey – Visit Survey 2.0. The survey tool will be continually re-evaluated by leadership of the Pediatric Specialty Care Network. Additional elements will be added as necessary to assure that improvements are progressive.

P-4: Conduct PDSA cycles: Improvement targets that are identified through the Visit Survey will be formally addressed through improvement efforts, and tracking of the effects of the improvement will be followed through ongoing use of the Visit Survey. Improvement efforts and education will occur through a Learning Collaborative internal to the Pediatric Specialty Care providers (physicians and NPs) and the staff supporting the clinics. These efforts will take place in DY3-DY5.

P-5: Disseminate findings: Patient Satisfaction results will be distributed quarterly to providers and leadership. Specific guidance around findings will be given and individual specialty clinic sites will be empowered to adopt changes to improve patient satisfaction.

Relationship to other Projects:

Related to project 085144601.2.1. Reduce and prevent lead poisoning and asthma in children and adolescents by targeting environmental aspects of children’s health (TEACH)

Relationship to Other Performing Providers’ Projects in the RHP:

TBD

Plan for Learning Collaborative:

TBD. We anticipate that the information obtained through the use of the Agency for Healthcare Research and Quality tool “CAHPS Clinician & Groups Surveys – Visit Survey 2.0 (Child)” will yield improvement opportunities. We will use these to create improvement oriented learning opportunities that will share best practices and improvement strategies throughout the specialty network.
**Project Valuation:**
The overall target goal is to establish a network of pediatric specialty care clinics throughout greater San Antonio which will enhance the ability for all children in San Antonio and the surrounding region to have timely and convenient access to pediatric specialty care. This project will establish three unique, new sites for pediatric specialty care throughout greater San Antonio which will benefit the community by reaching out to various groups. With successful deployment of these clinics, we plan to create 54,000 new opportunities for children to see pediatric specialists through the end of DSRIP year 5. By reaching out through establishing community clinics, this will decrease the disruption to parents who work, and children who are in school, thus bringing additional benefit, beyond the direct healthcare benefits, and thereby also decreasing some of the hidden costs for parents. Overall health of the children of the region will be enhanced through effective delivery of care and effective communication with referring practitioners through the use of modern EMR application. These improvements will enhance access for all children to the new children's hospital and will support the addition of needed pediatric specialty care providers.
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<thead>
<tr>
<th>085144601.1.18 PASS 2</th>
<th>1.9.2</th>
<th>1.9.2 A-D</th>
<th>1.9.2 Improve Access to Specialty Care (Pediatric Specialty Care Network)</th>
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<td>TPI - 085144601</td>
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<td>3.1T-6.1</td>
<td>Improvement in Patient Satisfaction Scores</td>
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<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
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<td>Milestone 1&lt;br&gt;[P-1]: Conduct specialty care gap assessment based on community need</td>
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<td>Milestone 7&lt;br&gt;[P-11]: Launch/expand a specialty care clinic: Goal: Add Pediatric Specialty Clinic Site in North Central San Antonio</td>
<td>Milestone 11&lt;br&gt;[P-11]: Launch/expand a specialty care clinic: Goal: Add Pediatric Specialty Clinic Site in Southeast San Antonio</td>
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<td>Milestone 7 Estimated Incentive Payment: $670,315</td>
<td>Milestone 11 Estimated Incentive Payment: $862,481</td>
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<td>Milestone 2&lt;br&gt;[P-3]: Collect baseline data for wait times, back log, and or return appointments.</td>
<td>Milestone 4&lt;br&gt;[P-8]: Develop the technical capabilities to facilitate electronic referral. Goal: EpicCare will be implemented in the new Pediatric Specialty Clinic.</td>
<td>Milestone 8&lt;br&gt;[P-8]: Develop the technical capabilities to facilitate electronic referral. Goal: EpicCare will be implemented in the new Pediatric Specialty Clinic.</td>
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<td>[I-24]: Implement specialty care access programs, e.g., referral technologies, Goal: 20% of the referring providers will be enrolled in EpicCare.</td>
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<td>[I-33]: Increased number of specialty care visits. Goal: A total of 24,000 patients will be seen in the specialty clinics</td>
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<td>Metric [I-33.2]: The number of patients seen in the pediatric specialty clinics.</td>
<td></td>
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<tr>
<td>Data Source 10: Medical Records</td>
<td></td>
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<tr>
<td>Milestone 13 Estimated Incentive Payment: $862,481</td>
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<tr>
<td>Milestone</td>
<td>Estimated Incentive Payment</td>
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<tr>
<td>Milestone 6</td>
<td>$624,384</td>
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<tr>
<td>Milestone 10</td>
<td>$670,315</td>
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</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount: $2,270,886**

**Year 3 Estimated Milestone Bundle Amount: $2,497,537**

**Year 4 Estimated Milestone Bundle Amount: $2,681,262**

**Year 5 Estimated Milestone Bundle Amount: $2,587,445**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,037,130**
Identifying Project and Provider Information:

Title: 1.10.1 Enhance improvement capacity within people [redesign to improve patient experience]
Unique RHP ID#: 085144601.1.20 – PASS 2
Performing Provider: University of Texas Health Science Center San Antonio-Laura Monroe
TPI: 085144601

Project Summary:

Provider Description:
The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. Located in Bexar County, we serve a large, Spanish-speaking, Medicaid population: 20% of our patient population is covered under Medicaid, almost an equal percentage to our Commercial payor population.

Intervention(s): The project will implement the CG-CAHPS patient experience survey among patients on behalf of all UT Medicine providers. All patients have an equal chance of being chosen to provide feedback via a 6-page survey, mailed to them in their preferred language.

Need for the project: Implementation of CG CAHPS is in line one of the Strategic Directions put forth by Bexar County’s Community Health Assessment (a document which laid out the biggest needs for Bexar County): more direct community involvement in healthcare. We currently have no way to measure patient satisfaction and experience, and as such, have been implementing quality improvement efforts without the input of the community. The CG-CAHPS survey will provide patients a direct way to become involved in their care, resulting in a more engaged, adherent patient population.

Target population: The target population is all of the patients seen at our UT Medicine clinics. 50 patients per provider will be selected randomly via a computer. 20% of our patient population is covered under Medicaid, and this intervention gives this often underrepresented patient population the opportunity for direct feedback.

Category 1 or 2 expected patient benefits: With the feedback that we received from over 8,000 patients, we will be able to identify operational inefficiencies in each of our clinics. Refinement of these operational processes will result in increased capacity and greater access for our patients across demonstration years (DY).

Category 3 outcomes: Research has shown that patient care experiences positively correlate to clinical quality processes and outcomes on both the practice and provider levels. We aim to increase patient experience scores in two domains specifically: to increase patient satisfaction scores for all providers on at least one measure from CG-CAHPS by 2.5% in year 4, and to increase patient satisfaction scores on shared decision making for all providers by 3% in year 5.
Project Description:
Providers at the MARC and CTRC currently have no way to measure patient experience, a measure that is becoming an explicit component of compensation and certification. Implementation of CG CAHPS is in line with two of the Strategic Directions put forth by Bexar County’s Community Health Assessment, a document which laid out the biggest needs for Bexar County. Patient care experience is broadly recognized as a core element of healthcare quality and also correlates to key financial indicators. The CG-CAHPS survey measures a broad range of core areas including access to care, provider communication, courtesy of clinic staff, how the patient would rate the provider, and whether or not they would recommend the clinic to family and friends. This invaluable information is presented in clear reports via the Catalyst program of NRC Picker, making the development and implementation of systems change easy, intuitive, and best of all, measurable.

The questions will be consistent across service lines so we will be able to see actionable system problems that have broad quality and efficiency implications. In implementing the evidence-based Clinician and Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) at UT Medicine, we aim to measure and improve patient experience of care. The significance of this goal will be realized through increased patient loyalty, a more engaged and adherent patient population, and increased clinical quality.

Starting Point/Baseline:
The proposed project will include 50 randomly selected patients per UT Medicine providers, or 8750 patients total. By making available patient experience data available by provider, each provider will be more empowered to improve patient experience by targeting interventions and support in the areas that are needed most. We do not currently have a baseline for our providers in terms of patient care experience. This is part of the problem. With the implementation of CG-CAHPS, we will be able to not only get a baseline for our providers, but compare that baseline nationally with other institutions.

Core Project Components:
(a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture.
(b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency, and other issues aligned with continuous process
(c) Implement CG-CAHPS survey to evaluate and improve patient satisfaction

Quality:
To achieve continuous quality improvement we shall assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to
better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

**Rationale:**

Implementing the CG-CAHPS and CG-CAHPS/PCMH surveys fills two of the gaps recently identified by the most recent Bexar County Community Health Leadership Community Health Assessment: an increased focus on systems change and increased engagement with the community in improvement initiatives. Implementing the CG-CAHPS is a direct way to engage community members in providing feedback regarding the quality of their care experience. And unlike traditional patient satisfaction tools, CG-CAHPS asks behavior-based, patient experience questions to uncover whether and to what frequency patient-centered behaviors occurred during the patient’s visit. By providing this focused feedback, patients bring to light where care providers are consistently meeting or exceeding their expectations, and where they are not. In order to deliver higher quality care to Bexar County residents and beyond, we must have their direct feedback. Additionally, The CG-CAHPS survey measures a broad range of core areas including access to care, provider communication, courtesy of clinic staff, how the patient would rate the provider, and whether or not they would recommend the clinic to family and friends. This invaluable information is presented in clear reports via the Catalyst program of NRC Picker, making the development and implementation of systems change easy, intuitive, and best of all, measurable. The questions will be consistent across service lines so we will be able to see actionable system problems that have broad quality and efficiency implications. This project presents a new initiative for UTHSCSA as it has never been done in the past. I am not aware of any similar projects currently being funded by DHHS at UTHSCSA.

CN.1 Addresses community need for greater emphasis on quality.

**Related Category 3 Outcome Measure(s):**

We selected the Category 3 stand alone outcome domain of Patient Satisfaction. Research has shown that patient care experiences positively correlate to clinical quality processes and outcomes on both the practice and provider levels. Additionally, patients with better care experiences are more engaged and adherent, and have better health outcomes. For example, a recent study in the *Journal of Family Practice* demonstrated that adherence rates were 2.6 times higher among primary care patients whose providers had “whole person knowledge” of them compared to patients of providers without that knowledge. This translates to better, more cost effective healthcare and healthier patients.

There are also other financial implications to consider, in the form of incentives, lower malpractice risk, and increased patient loyalty. Increasingly, patient experience is being tied to financial incentives, as is the case in Massachusetts and California. And with the passage of the new healthcare law, Centers for Medicare and Medicaid Services (CMS) will be making

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mandatory the implementation and reporting of patient experience survey results, and tying these measures to financial incentives. We will most likely be monetarily penalized for not collecting and reporting on this data. The implementation of CG-CAHPS now puts us in the position to have better scores once we are mandated to report them publicly.

Tracking patient experience data is cost efficient in other ways. The *Journal of the American Medical Association* has published several articles demonstrating that good patient experience correlates with lower medical malpractice risk. In fact, a 2009 study found that with each drop in patient-reported score along a five-step scale from “very good” to “very poor”, the likelihood of being named in a malpractice suit increased by 21.7%. Measuring patient experience using the CG-CAHPS and with the assistance of NRC Picker Service alerts is a hands-on approach for identifying and addressing issues in care that could lead to lawsuits.

Lastly, it is well known that patients keep or change providers based upon experience. Relationship quality is a key predictor of patient loyalty, and in Bexar County where patients have many choices for their healthcare needs, they can vote with their feet.

**Relationship to other Projects:**
This project directly supports those seeking to enhance/expand medical homes. When a medical home uses the CG-CAHPS survey, special recognition is given to that site.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Providers at Methodist, University Health System, CHOSA, and CSR are proposing similar projects to improve patient satisfaction and the patient care experience.

**Plan for Learning Collaborative:**
Implementing CG-CAHPS is a huge endeavor. Being able to share challenges and solutions, brainstorm ideas, and work together with other providers going through the same process will be invaluable. Our collaborative will establish goals, develop a calendar of regular meetings, and develop a plan to communicate ideas/data/successes.

**Project Valuation:**

**Achieves Waiver Goals:** This project assures that patients—regardless of their income level or insurance status—will be full partners in their healthcare by providing feedback on their experiences. Previous research in this area shows that measuring and improving patient experience results in a more engaged and adherent patient population with better health outcomes.

**Address Community Need(s):** This project addresses community priority needs described in the Community Health Improvement Plan for Bexar County for: Healthy Eating and Active Living.

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45 Fullam F, Garman AN, Johnson TJ, and Hedberg EC. The use of patient satisfaction surveys and alternate coding procedures to predict malpractice risk. *Medical Care* 47 (5).

and Behavioral and Mental Well-Being. Priority issues addressed by this project are health care quality and satisfaction. Indigent populations are notoriously underrepresented in studies of healthcare quality and satisfaction. However, our mail-based survey gives each patient an equal chance of being chosen to provide feedback. NRC Picker continues to follow up with the patient until a response is provided, or until the patient declines to provide feedback. This ensures this underrepresented patient population will be included in our feedback.

**Project Scope:** The proposed project will include 50 randomly selected patients for all 175 UT Medicine providers (8750 patients total, per year). By making available patient experience data available by provider each provider will be more empowered to improve patient experience by targeting interventions and support in the areas that are needed most.

**Project Investment:** The expected investment in this program for Human Resources will include the cost of a staff member to oversee the project onsite in conjunction with NRC Picker, the company who will be administering the surveys. Survey implementation will already be underway by year 2, allowing us to begin to develop and implement improvement plans in year 3.
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Milestone 3</th>
<th>Milestone 4</th>
<th>Milestone 5</th>
<th>Milestone 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-5]: Enhance the organizational infrastructure and resources to store, analyze, and share patient experience data as well as utilize them for quality improvement</td>
<td>[I-7]: Implement quality improvement data systems, collection, and reporting capabilities</td>
<td></td>
<td>[I-8]: Create a quality dashboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures</td>
<td>[P-9]: Participate in face-to-face learning twice in this DY with other providers and the RHP to promote collaborative learning around shared/similar issues</td>
<td>[P-X]: Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency, and other issues aligned with continuous process improvement</td>
</tr>
<tr>
<td>Metric [P-5.1]: Number of new patient experience measures being collected)</td>
<td>Metric [I-7.1]: Number of reports generated through these quality improvement data systems. Numerator = number of reports generated</td>
<td></td>
<td>Metric [I-8.1a]: Submission of quality dashboard</td>
<td>Data Source: Quality improvement data systems</td>
<td>Data Source: Suggestion process policies and procedures</td>
</tr>
<tr>
<td>Goal: Increased number of new patient experience measures being collected from 1 to 5</td>
<td>Goal: Increase the number of reports generated through these quality improvement data systems by 25%.</td>
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<td>Improvement Milestone Estimated Incentive Payment: $268,126</td>
<td>Goal: Establish an employee suggestion system within the year</td>
<td>Goal: Establish an employee suggestion system within the year</td>
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<tr>
<td>Data Source (p-5.1b): Documentation of methodology for patient experience data collection and reporting</td>
<td>Data Source: Quality improvement data systems</td>
<td>Milestone 2 Estimated Incentive Payment: $249,753.50</td>
<td>Data Source 1.8.1b: Quality improvement data systems</td>
<td>Milestone 6 Expected Incentive Payment: $517,489</td>
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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>085144601.1.20 PASS 2</td>
<td>1.10.1</td>
<td>1.10.1 (A, B)</td>
<td>1.10.1 ENHANCE IMPROVEMENT CAPACITY WITHIN PEOPLE [REDESIGN TO IMPROVE PATIENT EXPERIENCE]</td>
</tr>
</tbody>
</table>

University of Texas Health Science Center at San Antonio | TPI - 085144601 | Related Category 3 Outcome Measure(s): 085144601.3.29 3.1T-6.1 | Percent improvement over baseline of patient satisfaction scores |
<table>
<thead>
<tr>
<th>Metric [P-X.1]</th>
<th>Data Source</th>
<th>Goal</th>
<th>Milestone 3 Estimated Incentive Payment: $249,753.50</th>
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<tbody>
<tr>
<td>Number of training classes given during the year</td>
<td>Submission of training program materials and training sign in sheets</td>
<td>Implement a staff training program on patient experience</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric [P-9.1]</th>
<th>Data Source</th>
<th>Goal</th>
<th>Milestone 5 Estimated Incentive Payment: $268,126</th>
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</thead>
<tbody>
<tr>
<td>Participate in semi-annual face to face meetings organized by the RHP</td>
<td>Documentation of semi-annual meetings including agendas, slides, or notes.</td>
<td>Participate in 2 face to face meetings this DY.</td>
<td></td>
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<tr>
<th>Year 2 Estimated Outcome Amount: $454,177</th>
<th>Year 3 Estimated Outcome Amount: $499,507</th>
<th>Year 4 Estimated Outcome Amount: $536,252</th>
<th>Year 5 Estimated Outcome Amount: $517,489</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,007,425**
Identifying Project and Provider Information:
Title: 1.9.2 Improve Access to Specialty Care (Outreach Epilepsy Clinic – Uvalde)
Unique RHP ID#: 085144601.1.23 – PASS 2
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Project Summary:

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): The goal of this proposal is to deliver epilepsy care to the underserved area of Uvalde by providing an outreach clinic for patients with epilepsy. Epilepsy specialist physicians and support staff comprised of a case manager, social worker, and medical assistant will travel to Uvalde once every other month at the beginning of the project and increase the frequency of the services as needed in response to increasing need.

Need for the project: Epilepsy is a chronic medical condition that is best treated in an outpatient clinic setting by neurologists with specialized training in epilepsy. When people with epilepsy do not have access to specialty care, they generally seek care in the Emergency Department (ED). Care in the ED is not sufficient for long-term effective management of seizures. Repeated use of the ED for seizure results in poor medication compliance and poor seizure management. By providing access to neurologists, patients with epilepsy will have improved seizure management which will reduce the need to visit the ED.

Target population:

Patients with epilepsy and/or seizures.

Category 1 or 2 expected patient benefits:

This project seeks to provide 60 visits in the outreach clinic in DY2 and increase the number of visits by 30 pct above baseline (76 visits) in DY3, 60 pct above baseline in DY4 (92 visits), and 80 pct above baseline in DY5 (108 visits).

Category 3 outcomes:

IT-9.2 ED appropriate utilization

The goal of this project is to reduce ED visit rate for seizures by 50 percent over current rates by DY5 for patients followed in this clinic.

The five-year expected outcome for this project is to provide approximately 285 patient visits and reduce the ED visit rate for seizures for patients receiving care in the outreach clinic by 50
percent over the initial ED visit rate.

**Project Description:**

**Brief Description:** The goal of this proposal is to develop a mechanism to deliver epilepsy care to underserved areas in South and West Texas. The main focus of the outreach program will be to provide expanded outpatient care to people with epilepsy, both insured and indigent, who are predominantly Latinos. We are already providing this service to patients in Harlingen, Texas in collaboration with the Epilepsy Foundation Central & South Texas (EFCST) (see baseline data below). We are proposing to expand this care to additional areas with the greatest needs including Uvalde. Our epilepsy specialists and EFCST staff will travel to these remote clinics one day every two months at the beginning of the project, and increase the frequency of services as the project proceeds and in response to increasing need. The services would continue to be provided jointly with the EFCST. EFCST would also provide subsidies for medical therapies, access to medication assistance programs from Pharma, social services for employment, behavioral health services, disability applications, epilepsy education, and access to support groups. EFCST serves over 23,000 individuals in 79 Texas counties annually. The funding requested will support a nurse case manager, physician services, and travel, and food for the nurse case manager and physicians traveling to these underserved areas.

**Goal:** The specific objective is to develop outpatient epilepsy services for the underserved populations of Uvalde as an extension of what is already being done in Harlingen (see baseline data below). In addition, the outreach clinics will provide community access to the services offered by the South Texas Comprehensive Epilepsy Center in San Antonio and the educational and social service resources of the EFCST.

**Scope of the Problem:** There are 6.4 million uninsured people in Texas, with 172,800 diagnosed with epilepsy. The uninsured generally seek care through emergency room or primary care settings which are not adequately prepared to diagnose and treat epilepsy. There are direct (medical costs) and indirect (work-related) costs when patients don’t receive the specialty care they need. Given the lack of access in these areas to epilepsy specialty care even for those individuals who have some type of insurance, the opportunity to improve care for epilepsy patients in these areas is even greater. Information attached below provides details about the demographics of epilepsy service needs of the proposed service area.

**Challenges/Issues:** Delivery of any type of specialty care to an underinsured, immigrant population is a large challenge. Health care services and infrastructure are rudimentary in most of our targeted locations. For this proposal to succeed, outreach to local physicians, hospitals, schools, and social service providers, among others, will be crucial. Our project will provide access to patients, but we must first raise community awareness of the service so patients will be able to benefit from it. Another challenge is the poverty in our targeted service areas. Many patients cannot afford necessary tests and medications to appropriately treat their epilepsy. By partnering with the EFCST, who has resources to help underwrite tests and help patients get medications, we will dramatically improve outcomes by helping patients get access to the diagnostic services and treatments they need. Even with access to medications, medication compliance is a big issue, as well. A recent study found that 26% of patients with insurance were non-compliant with their epilepsy medications, leading to an increase in hospitalizations and emergency room visits. For the uninsured, the problem is even worse. Our plan to provide robust educational services – in English and Spanish – will help patients understand what to expect from their medications and why it is important to take them as directed. We anticipate that this will improve compliance, and decrease seizure frequency and trips to the ED. As described
above, 75% of medically refractory seizure patients may be helped by epilepsy surgery or other non-medical therapies. Currently, most epilepsy patients in these regions have no access to this type of treatment. By partnering with the South Texas Comprehensive Epilepsy Center at University Hospital in San Antonio, with financial help from the EFCST, these potentially life-changing treatments will now be an option for patients.

As described in the Baseline Data section, approximately 37% of patients seen in our Harlingen location have some type of medical insurance (predominantly Medicaid and Medicare, with a smaller number with other insurance). Given the lack of neurology, let alone epilepsy, specialty care, we anticipate that the insured and uninsured patients served will continue to be seen by our group in the future rather than make the long trip into San Antonio for care. In addition, we anticipate that approximately 20% of patients per year seen in each clinic location will be candidates for an epilepsy surgery evaluation at University Hospital, which will bring in additional revenue that will help support the physician costs of the program.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

Outreach epilepsy services are currently provided to patients in Harlingen in collaboration with the Epilepsy Foundation Central & South Texas. The clinic, in operation for 10 years, occurs 2 days every other month and provided 689 visits to 349 patients in FY11. To date, there have been a total of 92 patients from this out-reach clinic who have had epilepsy surgery at the South Texas Comprehensive Epilepsy Center at University Hospital.

Rationale:

Given that people living in this area do not have access to specialty care even if they have some type of health insurance, the opportunity to improve care of the patients with epilepsy is great. Many of these people use the emergency department frequently because of this lack of access. The total population for the Uvalde Clinic catchment area is 67,416. Of this population, there are approximately 1,348 individuals with epilepsy with an estimated 30 percent (404) who are indigent.

We expect to reduce emergency room visits through implementation of this project. Epilepsy surgery and other non-medical treatments may benefit as much as 75 percent of patients with
medically refractory epilepsy (patients who are not helped by appropriate antiepileptic therapy). Patients with frequent seizures are unable to drive, have difficult holding jobs, and are risk for seizure-related sudden death.

We are unaware of any projects underway at UTHSCSA funded by the US Department of Health and Human Services serving a similar purpose as the project being submitted.

CN.3 This project addresses the community need for greater access to medical care.

## Related Category 3 Outcome Measure(s):

**IT-9.2** ED appropriate utilization

The above outcome measure was selected to:
- measure reduction in visits to the emergency department resulting from improved seizure medication compliance/seizure management

## Relationship to other Projects:

UTHSCSA submitted a proposal to expand neuropsychological services. Patients served by this proposal benefit from neuropsychological testing as effective characterization of neurocognitive changes aid in patient management, diagnostic clarification, prediction of disease progression, assessment of functional status, and development of treatment recommendations.

## Relationship to Other Performing Providers’ Projects in the RHP:

This project is related to the following request:

UTHSCSA 1.9.2 Neuropsychology Services.

## Plan for Learning Collaborative:

The South Texas Comprehensive Epilepsy Center based at University Health System in San Antonio consists of a multidisciplinary group of physicians and staff. This group meets weekly to review cases, exchange ideas, and discuss best practices/approaches to patient management. Services provided under this proposal will be included in these weekly discussions.

## Project Valuation:
People with epilepsy who do not have access to specialty care generally seek care in an emergency room, at an average cost of $3,000 per visit. Difficulty in accessing needed medications will lead to noncompliance at a cost of about $5,000 per person. For those uninsured and without some type of assistance, epilepsy medications can’t be accessed through Pharma assistance programs ($1,338,525 in such assistance was facilitated by the EFCST in FY 2010 alone) and lost productivity in terms of work-related earnings for people with uncontrolled epilepsy amount to $8,953 per year per household. With seizure control due to appropriate treatment, approximately 60% of could return to work. The cost savings realized by this proposal detailed below is conservative, as it primarily accounts for benefits to those who are uninsured. As mentioned above, approximately 37% have some type of insurance and will be benefitted as well. The table below provides the data used to estimate the conservative value of this proposal in terms of cost savings.

Cost Savings of This Proposal

<table>
<thead>
<tr>
<th>Total with epilepsy</th>
<th>Number of uninsured with uncontrolled epilepsy (40%)</th>
<th>Direct Cost of uncontrolled epilepsy in uninsured ($9939/person/year)</th>
<th>Indirect of uncontrolled epilepsy in uninsured ($8953/household/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,348</td>
<td>162</td>
<td>$1,610,118</td>
<td>$1,450,386</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td></td>
<td></td>
<td>UNIVERSE OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO</td>
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</tr>
<tr>
<td>085144601.3.32</td>
<td>3.1T-9.2</td>
<td>ED appropriate utilization</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 1**
- P-1: Conduct specialty gap assessment based on community need
- **Metric 1** P-1.1 Documentation of gap assessment
  - Baseline/Goal: Conduct gap assessment
  - Data Source: Needs assessment
- **Milestone 1 Estimated Incentive Payment:** $151,392

**Milestone 2**
- I-22 Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties
- **Metric 1** I-22.1 Increase number of specialist providers
  - Baseline/Goal: Increase

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 4** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service
  - **Metric 1** I-23.2 Documentation of increased number of unique patients
    - Goal: Increase visits provided to 30 percent above baseline in year 2 (72 visits)
    - Metric: Clinic Visits
    - Data Source: Epic
  - **Milestone 4 Estimated Incentive Payment:** $499,507 |
| **Milestone 5** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service
  - **Metric 1** I-23.2 Goal: Increase visits provided to 60 percent above baseline in year 2 (96 visits)
  - Metric: Clinic Visits
  - Data Source: Epic
  - **Milestone 5 Estimated Incentive Payment:** $536,252 |
| **Milestone 6** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service
  - **Metric 1** I-23.2 Goal: Increase visits provided to 80 percent above baseline in year 2 (108 visits)
  - Metric: Clinic Visits
  - Data Source: Epic
  - **Milestone 6 Estimated Incentive Payment:** $517,489 |
<table>
<thead>
<tr>
<th>Milestone 2 Estimated Incentive Payment: $151,392</th>
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</table>

**Milestone 3**
P-11: Launch/expand a specialty care clinic  
**Metric 1 P-11.1**
Establish/expand specialty care clinics  
Baseline/Goal: Establish clinic; provide 60 clinic visits projected  
**Metric: Number of visits**  
Data Source: Epic  
**Milestone 3 Estimated Incentive Payment: $151,393**

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $454,177</th>
<th>Year 3 Estimated Milestone Bundle Amount: $499,507</th>
<th>Year 4 Estimated Milestone Bundle Amount: $536,252</th>
<th>Year 5 Estimated Milestone Bundle Amount: $517,489</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,007,425**
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system. Child Crisis Respite through Therapeutic Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 1268443-05.1.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
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<tr>
<td>Performing Provider TPI: 126844305</td>
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### Project Summary:

<table>
<thead>
<tr>
<th>Provider Description: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 and extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Severe Emotional Disturbance (SED) that DSHS identifies as the &quot;priority population.&quot; BTCS is the only publicly funded behavioral health provider in the County of 131,533 in population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention(s): This project will implement Treatment Foster Care (TFC) sites in Guadalupe County to provide crisis respite services to youth in psychiatric crisis. Youth will be assessed and if eligible placed in foster homes for an average of 45 days but long enough to resolve the crisis and initiate therapeutic services for youth and family. Admission to TFC will be accessible 24 hours a day.</td>
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<tr>
<td>Need for the project: We will address the RHP 6 Community Needs Assessment CN. 4 “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services.” There are no facilities for uninsured or underinsured youth in Guadalupe County and all crises must be taken to facilities in Bexar County. The target population for this service is poor, uninsured or underinsured youth and families. These families cannot afford to travel to San Antonio to participate in treatment and discharge planning.</td>
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<tr>
<td>Target population: The Target population is high risk youth diagnosed with Severe Emotional Disturbance the majority of them involved in Juvenile Justice who are in behavioral health crisis and who are poor, uninsured and/or underinsured. BTCS served 1,292 youth in its 8 County region in FY 2012, 76% of the youth were eligible for CHIP or Medicaid. We expect over 80% of those benefitting from these services will be uninsured or enrolled in CHIP or Medicaid.</td>
</tr>
<tr>
<td>Category 1 or 2 expected patient benefits: The project seeks to provide 730 crisis respite bed days in DY 4 serving 16 youth; and to provide 1,460 crisis respite bed days in DY 5 serving 30 youth.</td>
</tr>
<tr>
<td>Category 3 outcomes: IT- 9.1 Our goal is to decrease mental health admissions and readmissions to criminal justice settings, i.e., juvenile justice residential facilities out of Guadalupe County and referral by Guadalupe County Juvenile Probation to TYC and to juvenile detention facilities in any County, by a percentage TBD after baseline is established in</td>
</tr>
</tbody>
</table>
Project Description:

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 and extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Severe Emotional Disturbance (SED), that DSHS identifies as the “priority population.”

BTCS proposes to develop a specialized therapeutic foster care setting (also called ‘treatment foster care’) that can be used to intervene with the target population, youth diagnosed with SED in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility. Specifically, this setting will be used to provide a safe environment to begin reintegration and family reunification following diversion or discharge from hospital or residential facility. We will locate willing foster care homes in Guadalupe County certify these homes and provide specialized training to foster families. Therapeutic Foster Care is a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In Therapeutic Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Therapeutic Foster Programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.

Youth diagnosed with SED generally have adjustment or functioning difficulties in more than one life domain and therefore are usually served by more than one child serving agency in the community including specialized school programs, juvenile probation as well as mental health and substance abuse providers. These youth experience self-identified or family-identified crises that put them in danger of removal from the home and transfer or physical relocation to distant communities for inpatient or secure residential care, usually under contract with juvenile probation. BTCS is responsible for transitioning youth from the state hospital system. We also work with local partners in coordinating care for the persons returning from private hospitals and residential settings; however, youth who are separated from their families are less likely to make a quick recovery and have difficulty re-integrating into family life without active participation in therapy services by the family unit. Families who have limited financial and external support are unable to travel to San Antonio or out of region to participate in hospital or residential treatment facility scheduled treatment meetings, treatment planning, therapy sessions and other re-integration activities. The limited family participation results in children who are often unable to stabilize and return home. This causes disruption in families, in child and adolescent development and leads to increased involvement with the juvenile justice system. Crisis Respite through Therapeutic Foster Care offers families and youth a chance to return home. Specific Improvement Targets relating to reductions in justice involvement for these youth are included in the table.

According to the Community Needs Assessment published by RHP 6 Guadalupe County is
one of the fastest growing Counties in the Region. The Assessment also identifies the entire county as a Health Provider Shortage Area by HRSA for both primary care and behavioral health care. BTCS participates in the Mental Health Task Force for this County and they identified a need for services to youth and families. This program of screening and early intervention in a community setting is a better alternative to address the challenges faced by these youth and families.

The goals of this project as it relates to BTCS are: to develop sites in Guadalupe County with trained foster parents recruited from within the communities and professional support provided by licensed and certified staff currently working for BTCS outpatient sites there; to place youth in these settings as an alternative to inpatient and secure residential settings. The goals for the youth and families are: to successfully reintegrate children with emotional and/or behavioral needs into their communities and families—families who are trained to have the skills to meet those needs; and to reduce the number of children who will be removed from home and placed out of county in juvenile probation contracted facilities. Stable families and increased access to care will result in better functioning and reduced reliance on juvenile justice interventions. The project meets the following regional goals: in support of the triple aim of CMS, the project ensures that youth receive high-quality patient centered care in the most cost-effective way; and this further develops a coordinated care delivery system. The Therapeutic Foster Care program will safely reduce the number of children in out-of-home care and expedite permanency for children currently in out-of-home placements; effectively maintaining a child with emotional and/or behavioral needs in a family setting. The program supports effective growth and relationships of the child through an intensive support and treatment program, this program is designed to assist children transitioning to a less restrictive environment—and, ultimately, into a healthy family situation. We support the following, nationally recognized definition of permanency: an enduring family relationship that is safe and meant to last a lifetime; offers the legal right and social status of full family membership; provides for physical, emotional, social, cognitive, and spiritual well-being; and assures lifelong connections to extended family, siblings, other significant adults, family history, traditions, race and ethnic heritage, culture, religion, and language. We believe that these family relationships help produce healthy and well-adjusted adults which strengthens the safety and security of our communities.

A major challenge for this program will involve the regulation and infrastructure needed to operate Foster Care services and to develop the philosophy of care to carry it out. We are certain that we can address the challenges and achieve the goal of this project because BTCS has reached agreement to collaborate with the Center for Health Care Services, (CHCS) the LMHA for Bexar County which is also a licensed Child Placing Agency and has been developing foster care sites for several years. The CHCS staff brings training and certification expertise. That staff along with the foster parents and BTCS staff in Guadalupe County will provide a therapeutic environment that will enable children in the area to stay connected to their families and community while learning the skills and coping mechanisms needed to be successful. Professional support will also be provided to the parents and key family members to develop skills strengthening the family unit, supporting successful reunification. There are a variety of evidenced based practices (EBP) that have been implemented in Therapeutic Foster Care settings, as noted in “Evidenced Based Practices in Treatment Foster Care- A
Over the next five years, we expect the outcomes for the youth and families to be: higher success rate for reintegration from residential treatment facilities as evidenced by longer average tenure than currently recorded with their natural family after discharge; a reduction in removals and placements out of the Region by Juvenile Probation; and a reduction in inpatient psychiatric placements. These outcomes are supported by the goals above, i.e., to establish this community alternative for crisis intervention that is cost effective, culturally competent and preserves families. The outcomes expected from this mental health program will address the needs in this Region.

**Starting Point/Baseline:**

Currently no Crisis Respite or Therapeutic Foster Care program exists in Guadalupe County and services are not provided for this group of involved with juvenile probation and experiencing crises. Therefore, the baseline is 0 in DY 2. We do not have data related to out of home placements through Juvenile Probation Department in Guadalupe County nor do we have a comprehensive picture of psychiatric hospitalizations for youth. We will undertake to identify resources and methods to capture and share information across these various child serving agencies.

**Rationale:**

Crisis Respite through Therapeutic foster Care expands the options for caregivers and agencies involved with these children and adolescents other than to assess and transport to San Antonio or even farther outside of RHP 6 for admission to a hospital or secure residential facility for stabilization. Aside from the distant locations of these stabilization options, we believe this is the best approach, an innovative use of a family oriented community setting rather than a more restrictive community institutional setting.

BTCS served 1,292 youth in FY 2012 most of whom had diagnoses that put them into the range of Serious Emotional Disturbance and were at or below the poverty level with multiple functional deficits to overcome. Guadalupe County saw a 47.8% increase in population from 2000 to 2010. According to that census data, 27.2% of the population is under 18 years of age and 36% is Latino. The Community Health Improvement Plan for Bexar County states that “Nearly 10 times as many Hispanic youth utilized state mental health services compared to the number of White and African American youth who utilized the same services.” There are no crisis behavioral health facilities or resources in the County. Families transport their child to an Emergency Department in their own community or in San Antonio because of concern for the safety and security of their child and family. Strategic planning sessions sponsored by the Bexar County Commissioners Court and Methodist Healthcare Ministries identified the following issue, “Inadequate and fragmented continuum of care for children with behavioral health diagnoses.” This project implements a crisis response for youth that addresses these identified gaps in the continuum of care.

The Crisis Respite through Therapeutic Foster Care project will address all of the required core project components:

a) **Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address**
identified gaps. Our focus will be to work with stakeholders who are child serving agencies and to identify gaps that lead to referral to juvenile justice. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services; the numbers of people removed by Juvenile Probation, taken to ED’s and admitted to private facilities.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service. We know that families transport their child to an Emergency Department in their own community or in San Antonio rather than contacting the LMHA because of the limited crisis response services and/or concern for the safety and security of their child and family. This creates a complex issue related to data identification and access. Working with community stakeholders and child serving agencies, we will identify tools to provide data to analyze the capacity for service, current utilization patterns and to identify the key characteristics of the people to be served.

c) Assess the behavioral health needs of patients currently receiving crisis services. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients. We will use the current staff to assess current needs of those who are now and have been detained in the last year.

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. Using the information from stakeholders, from capacity and utilization tools and from assessment of those detained, we will assess the intervention we are providing as to acceptability and feasibility to scale into other facilities in this County to increase capacity in Region 6.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. Finally, we will review the intervention and the changes to identify lessons learned and adjust the model with respect to area, intensity and population. There is guidance available, and we plan to take care that the evidenced based practice (EBP) approach will evolve from a thorough needs assessment process that considers how well it fits with the clients, the staff and the organization.

Unique community need identification numbers the project addresses are: CN. 4 “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services;” and CN.5 “Lack of interconceptional and prenatal care for women and primary and preventive pediatric care results in poor maternal and child health outcomes.”

This project significantly enhances delivery system reform by enhancing the holistic health care approach of BTCS and its partners, including Community Health Centers of South Texas, the FQHC for Guadalupe County. We have received a grant from HRSA to build a clinic together to co-locate behavioral health and primary care services in Seguin. This program is another innovative community alternative. It reduces the need for institutional care and not
only saves money but also provides families with limited resources, the opportunity to engage in therapeutic interventions with their child in order to learn how to be more capable parents and caregivers. The project will improve child integration into the natural family; reduce in involvement with Juvenile Probation and subsequent removal from the home and family. The increased capacity and access to these specialty services will decrease unnecessary utilization the most costly healthcare delivery services such as emergency departments, psychiatric emergency services and psychiatric hospitals. BTCS currently receives funds from US Department of HHS to operate substance abuse screening and referral service, OSAR in other counties, and Mental Health block grant funds for outpatient mental health services. Those HHS funds will not be used for direct services; this project enhances and extends the care currently provided with Federal funds by a new and innovative to behavioral health crisis services. We are certain this intervention will improve the healthcare outcomes for entire community and improve the ability of these young people to become contributing members of their communities.

**Related Category 3 Outcome Measure(s):**

The Category 3 Outcome Measure that we selected is “OD-9 Right Care, Right Setting” the IT selected was IT- 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.” This Improvement Target (‘IT’) language references criminal justice but more accurately, we are engaged in improvements related to juvenile justice. For the purpose of this project we are interpreting the IT to include the various levels of juvenile justice involvement to include residential treatment in a secure facility. We selected this measure because one of the key community partners in this project is the Juvenile Probation Department in Guadalupe County. Unfortunately, it is often the case that families have no options to care and treatment except through court action that removes custody and physically removes their child to a contracted Juvenile Probation residential facility. We feel treatment in the community rather than deeper and deeper involvement in the juvenile justice system would be a good predictor of success.

**Relationship to other Projects:**

BTCS has also proposed to establish a new outpatient substance abuse service in Guadalupe County that supports services to this group of youth, creating new opportunities for referral and care.

**Relationship to Other Performing Providers’ Projects in the RHP:**

This approach it child crisis services is different than the one proposed by CHCS and is for a population in a different County in RHP 6. We plan to coordinate care with CHCS and participate in learning collaborative with them so that we may both improve our systems of care.

**Plan for Learning Collaborative:**

BTCS will participate in all learning collaboratives organized or sponsored by University Health System that are relevant to our projects. We believe it is important to improving and adjusting the care provided.
<table>
<thead>
<tr>
<th><strong>Project Valuation:</strong></th>
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<tr>
<td>The project seeks to provide 730 crisis respite bed days in DY 4 serving 16 youth; and to provide 1,460 crisis respite bed days in DY 5 serving 30 youth. This valuation used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on the cost utility model and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. We assigned a value of $2,395,828 through DY 5. Complete write-up of project will be available at performing provider site.</td>
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<tr>
<td>Outcome Measure(s):</td>
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<tr>
<td>Year 2</td>
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<td>Milestone 1</td>
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Milestone 1 Estimated Incentive Payment: $271,767
Milestone 2 Estimated Incentive Payment: $271,767
Milestone 3 Estimated Incentive Payment: $596,867
Milestone 4 Estimated Incentive Payment: $638,510
Milestone 5 Estimated Incentive Payment: $616,917
**Milestone 2 P-3:** Develop implementation plans for needed crisis services. 
**Metric 1 P-3.1** Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. 
**Goal:** Produce a comprehensive plan that addresses the elements above. 
**Data Source:** Written plan 

<table>
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<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $543,534</th>
<th>Year 3 Estimated Milestone Bundle Amount: $596,867</th>
<th>Year 4 Estimated Milestone Bundle Amount: $638,510</th>
<th>Year 5 Estimated Milestone Bundle Amount: $616,917</th>
</tr>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,395,828
### Identifying Project and Provider Information:

**Title:** 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Substance Abuse Treatment and Intervention Services  
**Unique RHP ID #:** 1268443-05.1.2 – PASS 1  
**Performing Provider:** Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services  
**Performing Provider TPI:** 1268443-05

### Project Summary:

**Provider Description:** Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 and extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons residing in the area.

**Intervention(s):** BTCS proposes to enhance service availability by establishment of a community based setting where behavioral health services may be delivered in this underserved area. We will open and staff substance abuse services within our current clinic site in Seguin, Texas. That site has space and it is suitable for the service without renovation or capital expenditure. This outpatient substance abuse service site which establishes services that are new to BTCS and to the community will provide supportive outpatient services, i.e., group and individual counseling; and an intensive outpatient program for persons who have been diagnosed with and require treatment for substance use disorders.

**Need for the project:** This project addresses RHP 6 Community Needs Assessment needs: **CN. 3**  
Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages; and **CN. 4** There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services. There is only one licensed treatment provider in all of Guadalupe County and it does not serve primarily poor, uninsured and under insured.

**Target population:** Our target population is community referrals, and those referred from detoxification or ED’s who are poor, uninsured or underinsured and in need of outpatient substance abuse services. BTCS served 3,377 persons in Guadalupe County in FY 2012; 2,401 persons with behavioral health disorders. In FY 2012, an average of 43% of the adults were eligible for Medicaid; 73% of BTCS clients are below the federal poverty level; 55% are uninsured. We estimate that approximately 70% of those benefitting from this project will be poor, uninsured or underinsured.

**Category 1 or 2 expected patient benefits:** The project seeks to provide outpatient substance abuse services to 200 people in DY 4 and 400 people in DY 5.

**Category 3 outcomes:** IT-3.8 Our goal is to reduce the behavioral health/substance abuse 30 day readmission rate to detoxification and residential facilities by a percentage rate TBD after the baseline is established in DY 3.
Project Description:

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 and extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons residing in the area. As referenced in the Community Needs Assessment for RHP 6, page 14, the National Rural Health Association (NRHA) has identified several issues of particular interest to rural communities: and among them is lack of access to health care services, particularly health disparities and physician shortages; mental health services, particularly relating to provider shortages and lack of insurance coverage; and substance abuse services. Over the last year, staff of BTCS along with leaders and advocates participated in the Guadalupe County Mental Health Task Force to identify community needs. One of the most pressing deficiencies identified is lack of access to outpatient substance abuse treatment especially for the poor and uninsured or underinsured.

BTCS proposes to enhance service availability by establishment of a new substance abuse services within our current community based setting where behavioral health services may be delivered in this underserved area. Our current site has space and it is suitable for the service without renovation or capital expenditure. This new outpatient substance abuse service will include supportive outpatient services, i.e., group and individual counseling, and an intensive outpatient program for persons who have been diagnosed with and require treatment for substance use disorders. The goal of this project is to allow people who have limited resources to access outpatient substance abuse services in their home county. Many of these individuals will have this access following a detoxification or ED visit in adjacent Bexar county. Additionally the goal is to stop the cycle of detoxification or ED utilization and relapse that is triggered by inadequate access to supportive and intensive outpatient services.

The goal of the project is to establish this new outpatient service in Seguin in Guadalupe County to improve the availability of substance abuse services and targeting specifically the poor and uninsured. This project meets the following regional goals: achieving one of the CMS aims by improving the patient’s experience of care; will meet the regional need to reduce over utilization of ED’s in Bexar County by persons with behavioral health disorders.

The primary challenge to this project will be to achieve acceptance in the community of the need for and desirability of treatment for substance use disorders. The recovery community is under resourced and several agencies and services have ceased operation over the last several years. BTCS is a well-established the mental health provider and the LMHA in Guadalupe county and has a good relationship with the Federally Qualified Health Center and most health care providers in the community. We feel we are positioned to address the challenge by creating opportunities for community engagement and education concerning substance use and its impact.

Over the next five years we expect to an increase in the number of people accessing substance use disorder treatment and a concomitant reduction in the number of readmissions to detoxification facilities and substance abuse related ED visits for Guadalupe county residents,
both in Guadalupe County and in Bexar County. The goals stated above related to establishing this new service and educating the community about the need for intervention and treatment will directly affect achievement of these outcomes.

**Starting Point/Baseline:**

This is a new project for BTCS in Guadalupe County. There is no program for substance abuse treatment that targets the poor and uninsured and therefore the baseline for DY 2 is 0. We do not have current data to identify those from Guadalupe County who are accessing detoxification and ED services due to substance abuse disorders, but an important first step in this project will be link to Health Access San Antonio or some other means of gathering and tracking that data. We are also aware that we must secure licensure and for outpatient substance abuse services.

**Rationale:**

The primary intent of this project, which is to establish a new substance abuse service location within our current mental health clinic in an underserved area. There is one substance abuse provider in the County, but the focus of that service is not specifically on the poor and uninsured. Locating a service locally will increase utilization, eliminating the barrier of travel into Bexar County that prevents the economically disadvantaged from accessing care.

According to the Community Needs Assessment of RHP 6, eleven to twenty percent of the population of Guadalupe County is below the poverty level. Additionally, 24% of the people in the RHP 6 region are without insurance or any third party coverage. The entire county has been designated a mental health provider shortage area according to US Department of HHS, HRSA. The challenges for the people living in Guadalupe County are that there is only one licensed treatment provider in the County, the Teddy Buerger Center associated with Guadalupe Regional Medical Center. The Center accepts third party payments and operates on a sliding fee scale for those unable to pay, but it cannot meet the need of all the citizens of the County. It is especially not equipped to meet the needs of the poor and uninsured. Some services available in the adjacent Bexar County and frequently when there is a life threatening or dire crisis of some sort, people travel from Guadalupe County to Bexar county and access the ED’s and detoxification facilities. According to the Bexar County Consortium Report of 2012, the ED’s in Bexar County are over utilized by persons presenting with behavioral health conditions. That includes a substantial number of people from other counties. Once the crisis is over and the person is medically stable they return to Guadalupe County but are unable to access ongoing outpatient treatment to remain free of alcohol and drugs. The result is relapse and a return to ED’s and detoxification facilities.

Even though there are no Core Components associated with this option, but we plan to use the guidance found in other Options. We expect to carefully develop the project and then to adjust based on a rapid cycle quality improvement model. The development of this project will begin by reconvening community stakeholders during the remainder of FY 2013 to gather support for and assess the barriers to access to outpatient substance abuse services. With these stakeholders, we will identify tools to provide data to get current utilization of ED and residential services in Bexar County as well as ED use at the Guadalupe Regional Medical Center in Seguin and to assess the demand for outpatient services in Guadalupe County. BTCS operates a mental health clinic in Guadalupe County and is in process of building a new facility to co-locate services with
the Community Centers of South Central Texas, the FQHC in that County. We will use the staff and community resources we have in the county to assess current needs of those who are now accessing EDs and detoxification and then returning to the County. Using the information from stakeholders, from capacity and utilization tools, from further literature reviews and from assessment of those potential referrals, we will assess the intervention we are planning to provide. As we establish the new service within our outpatient site, we will plan a rapid cycle quality improvement component through our Quality Management Department at BTCS. We plan to continuously improve the program over the next 4 years as we adjust the volume of interventions and service array and make changes based on lessons learned. Those changes may include adjustments to the model with respect to interventions, intensity and population.

**This project addresses Community Needs Assessment needs:** CN. 3 Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages; and CN. 4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services.

This project will enhance the current delivery system reform initiatives by establishing this new community setting within the FQHC and improving access to behavioral health care while integrating that care with primary care. BTCS currently receives funds from US Department of HHS to operate substance abuse screening and referral service, OSAR in other counties. Those HHS funds are not used for direct outpatient services and are allocated in a different RHP. No other federal funding sources are used in this project.

**Related Category 3 Outcome Measure(s):**

The Category 3 Outcome Measure that we selected is “OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs ); IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.” This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been in some inpatient or other detoxification program to transition to stable living in the community by providing access to community outpatient services. The cycle of relapse and return to hospital or residential detoxification services is a major disruption for individuals seeking to achieve recovery. It is also costly to the health care system and devastating to individuals and families. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the program and a good indicator of success on a personal basis for those enrolled in the program. Low income individuals cannot now access outpatient care and are left in this cycle of relapse. Extended sobriety and productivity will improve their health outcomes.

**Relationship to other Projects:**

BTCS has also proposed in Category 2, Project 1268443-05.2.1. This project is the establishment of a patient navigator program for high utilizers of the ED at Guadalupe Regional Medical Center. The project to establish a new outpatient substance abuse service in the county supports the patient navigator project by creating new opportunities for referral and care.
**Relationship to Other Performing Providers’ Projects in the RHP:**

This project supports and enhances CHCS projects 3 and 4 by reducing the burden of homeless substance abusing individuals who are in need of the Haven for Hope services. We hope to participate with CHCS in coordinating care and learning from their approach to these vital services.

**Plan for Learning Collaborative:**

BTCS will participate in all learning collaboratives organized or sponsored by University Health System that are relevant to our projects. We believe it is important to improving and adjusting the care provided.

**Project Valuation:**

The project reduces inappropriate use of ED by this population which improves their lives through stable services in a medical home; and improves community health by opening access for those who truly need of ED. The project seeks to provide outpatient substance abuse services to 200 people in DY 4 and 400 people in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We valued this project at $1,387,058 through DY 5. Complete write-up of project will be available at performing provider site.
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<th>1268443-05.1.2 PASS 1</th>
<th>1.12.2</th>
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<tbody>
<tr>
<td><strong>1.12.2 EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: SUBSTANCE ABUSE TREATMENT AND INTERVENTION SERVICES</strong></td>
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Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services

TPI - 1268443-05

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>1268443-05.3.2</th>
<th>3.1T-3.8</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health/Substance Abuse 30 day readmission rate</td>
<td></td>
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<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**
P-3 Develop administrative protocols and clinical guidelines for projects selected

Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines

Goal: Produce a manual of operations that can be used to establish administrative and clinical practices.

Data Source: Administrative protocols; Clinical guidelines

Milestone 1 Estimated Incentive Payment: $314,678

**Milestone 2**
P-4. Milestone: Hire and train staff to operate and manage projects selected.

Metric 1 P-4.1: Number of staff secured and trained

Goal: Develop curricula and hire and train 4 staff, 2 licensed and 2 Counselors in training.

a. Data Source: Project records; Training curricula as develop in P-2

Milestone 2 Estimated Incentive Payment: $172,778

**Milestone 3**
P-6. Milestone: Establish behavioral health services in new community-based settings in underserved areas.

Metric 1P-6.1 Number of new community-based settings

**Milestone 4**

[I-X]: Number of patient interventions.

Metric 1 [I-X.1]: Number of patients in target population served in this new service.

Baseline/Goal: Baseline – 0, since no such services operated by provider are now located in RHP; Goal - serve a total of 200 in DY4.

Data Source: EHR

Milestone 4 Estimated Incentive Payment: $369,662

**Milestone 5**

[I-X]: Number of patient interventions.

Metric 1 [I-X.1]: Number of patients in target population served in this new service.

Baseline/Goal: Baseline – 0, since no such services operated by provider are now located in RHP; Goal – serve a total of 400 in DY5.

Data Source: EHR

Milestone 5 Estimated Incentive Payment: $357,163
where behavioral health services are delivered  
Goal: Establish 1 site  

Milestone 3 Estimated Incentive Payment: $172,777  

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<thead>
<tr>
<th>Year</th>
<th>Estimated Milestone Bundle Amount</th>
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<tbody>
<tr>
<td>Year 2</td>
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<td>Year 3</td>
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<tr>
<td>Year 4</td>
<td>$369,662</td>
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<td>Year 5</td>
<td>$357,163</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,387,058**
<table>
<thead>
<tr>
<th>Identifying Project and Provider Information:</th>
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<tbody>
<tr>
<td><strong>Title:</strong> 1.13.1 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization</td>
</tr>
<tr>
<td><strong>Unique RHP ID#:</strong> 121990904.1.1 – PASS 1</td>
</tr>
<tr>
<td><strong>Performing Provider:</strong> Camino Real Community Services</td>
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<tr>
<td><strong>Performing Provider TPI:</strong> 121990904</td>
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<th>Project Summary:</th>
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<tr>
<td><strong>Provider Description:</strong> Camino Real Community Services is a Local Mental Health Authority that provides outpatient mental health services to child, adolescent, and adult patients with severe and persistent mental illness. The provider is located in a 10,000 square mile rural service area with a total population of approximately 206,777. In 2012, the Center provided services to 3,538 adults and children that met criteria for services. The Mental Health Operating budget is approximately 6.9 million dollars. The programs work closely with schools, health centers, hospitals, law enforcement, judiciary and local elected officials to coordinate the provision of services.</td>
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**Intervention(s):** The project is to establish Crisis Stabilization Services in the service area. More specifically, it is the Center’s intent to provide a minimum of a 10 bed Crisis Residential Facility. |

**Need for the project:** Camino Real Community Services’ area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible crisis interventions. The designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. There are no local psychiatric hospitals or crisis stabilization facilities in the service area. The center provided 413 crisis assessments (January 2012 – August 2012) to individuals in the service area. Of the 413 approximately 140 patients were sent to inpatient psychiatric hospitals between January 2012 – August 2012. Currently there are no Federal Funds utilized for any Crisis Stabilization services in the Camino Real service area. |

**Target population:** The target population is individuals of all ages experiencing a psychiatric crisis and requiring crisis residential treatment. The center’s current behavioral health population is comprised of individuals who are indigent or Medicaid and/or Medicare eligible. It is anticipated that once the facility is fully operational, the expected service volume will be 108 persons per 12 month period. This assumes an average stay of 30 days per patient and a 90% occupancy rate. |

**Category 1 or 2 expected patient benefits:** The project intends to benefit patients by providing crisis residential services including psychiatric intervention, 24 hour active treatment by mental health professionals and rehabilitation and education services that enhance patient skills. It is the performing provider’s expectation that this model will improve access to the appropriate level of care for patients. The other benefits include decreasing travel for patients needing crisis stabilization services. |

**Category 3 outcomes:** OD-9, IT 9.4 Decrease Behavioral Health/Substance Abuse admissions and readmissions to institutional facilities including local emergency departments and psychiatric facilities.
Project Description:

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail, or an inpatient hospital bed. Unfortunately, a worst case scenario occurs when even these undesirable options fail, and the consumer is left to the care of family/friends until transportation and availability of an in-patient placement can be arranged. It leaves the person in crisis and the family at great risk and feeling frustrated with the system they turn to for help.

Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.1

The Camino Real Community Services area is vastly rural and has been designated as a Medically Underserved Area, Health Professional Shortage Area and Mental Health Shortage Area by the US Department of Health and Human Services Health Resources and Services Administration division. There are many challenges that accompany these designations. For instance, in the 10,000 square miles that comprise the portion of Region 6 that Camino Real is responsible for, none of the inpatient hospitals have a psychiatric unit to address the needs of the community. The lack of resources in the local community requires extensive travel into San Antonio for access to a private or public psychiatric facility in order to stabilize the person in crisis. Typically, local law enforcement provides transportation to these distant locations. The cost to the community is not only in the man hours and mileage costs associated with the transport, but the risk to the community when the peace officer is diverted from the responsibility of protecting the community to provide the needed transportation. The emotional cost to the person in crisis and their family/friends who wait for hours for logistics to be worked out in order to finally get to the help they need is immeasurable.

The project proposed by Camino Real is to develop local crisis stabilization services for persons in psychiatric crisis. This program will be designed and staffed to provide acute psychiatric intervention comparable to that received at remote psychiatric inpatient hospitals. This community based alternative will have a dramatic impact on frequency, duration and cost associated with usage of local hospital Emergency Rooms.

The local crisis stabilization services will assure that the right care is being provided in the right setting (OD-9.4.1). There should be a corresponding decrease of mental health admissions and re-admissions of persons needing crisis stabilization services to institutional facilities.

The target goal is to decrease use of higher cost services in Emergency Rooms and/or Inpatient Facilities. Additional goals would be to decrease travel for patients needing crisis stabilization
services. Inherent to the program design will be the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance consumer skills as they return to their homes.

By the end of the 5 year period and the establishment of crisis stabilization services, consumers in need, will be able to receive these services in their community. On average, drive times to services will be non-existent or would be no more than one hour. Response times to consumers will be significantly reduced ending long wait times in emergency rooms and/or long transport times to State Hospitals and other facilities. The efficacy of treatment will be significantly improved and overall costs to the total care system (not just hospitals) would be significantly reduced.

The project responds to needs as compiled in the RHP 6 Needs Assessment particularly CN 4 which states “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization”. Further the project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

**Starting Point/Baseline:**

No local 24 hour crisis stabilization services are available to community members who are in psychiatric crisis; persons either stay in hospital emergency rooms or are transported long distances to more restrictive inpatient service environments. In DY 2 and DY 3 planning and implementation processes will be in place to establish the project. DY 4 will see the hiring of staff and the initial provision of services with full services in place in DY 5. The Category 3 outcome measure baseline will be determined in years DY4 and DY 5 when program is implemented.

**Rationale:**

Camino Real has selected Project **Option #1.13.1**, Development of Behavioral Health Crisis Stabilization Services as alternative to hospitalization, with all the required core components. These are as follows:

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

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

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

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

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

Note a substantial number of the above Core Components are included in category 1 and category 3 milestones.

This selection is based on the fact that there are no local crisis stabilization services to persons in psychiatric crisis in the Camino Real service area. The population has a significant need as evidenced by the number of calls made to the local crisis hotline and the requests made for crisis assessment at local hospitals. It is responsive to Community Need #4 (CN4).

In 2008, Mental Health or Substance Abuse disorders were the principal reason for 1.8 million inpatient community hospital stays, accounting for 4.5 percent of stays in the U.S. This is according to Brief #117 (Agency for Healthcare Research and Quality, June 2011). It was also noted the MH and SA conditions most frequently treated in community hospitals were mood disorders (depression and bipolar disorder), schizophrenia and other psychotic disorders, alcohol-related disorders and drug-related disorders. These MHSA hospital stays cost $9.7 billion ($7.7 billion for MH; $2.1 billion for SA) accounting for 2.7 percent of all inpatient community hospital costs. Nationwide, the MH average length of stay was 8.0 days and the SA average length of stay was 4.8 days with an average cost $5100. In another publication (Kaiser Family Foundation, 2010) the prevalence of many serious health conditions such as cognitive or mental impairments, depression, and diabetes is significantly higher for dual eligible individuals. They are also some of the sickest and poorest individuals covered by either Medicare or Medicaid. Approximately 31% of the individuals served by the Performing Provider are dual eligible (Medicaid & Medicare).
This is a new initiative for the Performing Provider since there are no local crisis stabilization services available to persons in psychiatric crisis as an alternative in the local communities. Based on data reviewed from the provider’s local database the local population has a significant need as evidenced by the number of calls made to the provider’s crisis hotline and requests for crisis assessments by local hospitals. This results in a significant financial impact on local resources including law enforcement, judicial system and hospital emergency rooms. In addition, availability of inpatient psychiatric hospital beds in public and private facilities has been significantly reduced due to the demands of the forensic population. In Fiscal Year 2012 the center crisis hotline received 3016 calls with over 1000 of these requiring crisis assessments that resulted in 28% needing stabilization at higher cost inpatient facilities. The community needs cost effective local option for residents in crisis. In Texas the average cost of an Emergency Room visit is approximately $996 and an average stay at a state funded mental health facility is $400/day according to the 2011 report by Health Management Associate on “The Impact of Proposed Budget Cuts to Community Based Mental Health Services”. Furthermore the report supports the model of community based services as a better option for treating persons with mental illness in a more cost-effective local environment. In the Texas Fact Sheet-2011 Psychiatric Hospitals there were a total of 5391 psychiatric beds in the state with 49.3% of the beds being public beds, 14.4% were nonprofit beds, and 36.3% were for-profit beds. Two hundred and twelve counties in Texas do not have a psychiatric hospital and most hospitals are located in metropolitan areas. The Performing Providers Service area reported earlier has no psychiatric hospital available; therefore, individuals in crisis do not have access to a local option with regards to alternative crisis stabilization services.

Citations:

Directory of Active Hospitals, 2011, Health Facility Licensing and Compliance Division, Texas Department of Stated Health Services; Hospital Tracking Database, Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services.


Related Category 3 Outcome Measure(s):

The Category 3 Outcome measure selected for the Camino Real Community Services Development of Behavioral Health Crisis Stabilization Services as alternatives to Hospitalization Project is OD-9, Decrease Mental Health Admissions and Re-Admissions of persons needing crisis stabilization services to institutional facilities.

The reason for selecting this measure is that it captures the impact of having a local, cost effective alternative to higher costs systems such as jail, emergency room, or inpatient hospitalization when addressing crisis situations that can be quickly resolved. The project will track the number of admissions to the crisis facility and compare to historical data kept by the Center regarding the number of admissions to public and private in-patient psychiatric institutions to calculate cost avoidance. As the community becomes familiar with the crisis stabilization unit and diverts persons in psychiatric crisis from the jails and Emergency Room, crisis stabilization admission data will be tracked and calculation of cost avoidance to the ER and jails will be maintained to substantiate the cost effectiveness of this alternative.

Health Management Associates, in their March 2011 Impact of Proposed Budget Cuts to Community-Based Mental Health Services presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is $12 for adults and $13 for children, as compared to $401 for a State Hospital bed, $137 for a jail bed for an inmate with mental illness, and $986 for an emergency room visit. Camino Real anticipates that development of a crisis stabilization unit in the local community will also reduce costs to other stakeholders involved in the crisis response system which includes the local sheriff’s department and the judicial system.

Relationship to other Projects:

Camino Real is proposing one project in Region 6. It is category 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization with Quality Improvement 3.IT-9.4 Right Care, Right Setting.

It relates to other projects in the region by addressing the need for a local alternative for stabilization of crisis situations that are benign and are more appropriately addressed in a facility located within the service area. Hospital emergency rooms, law enforcement personnel, jails, programs of the center and other affiliated agencies will have the capability to place individuals in this facility. This project will compliment other activities and will be a clear alternative to options that are costly, involve extended wait times for consumers, use great amounts of local resources and involve long travel distances for people that are needing services.
### Relationship to Other Performing Providers’ Projects in the RHP:

By establishing crisis stabilization services as a local option, Camino Real Community Services supports the effort to have better outcomes for persons with mental illness in the service area in line with RHP Regional Goals:
- Triple Aim: assuring patients’ receive high quality and patient centered care, in the most cost effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties.
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

### Project Valuation:

Project valuation takes into consideration:
1) Costs for both State operated Psychiatric Hospitals
2) Cost of private Psychiatric Hospitals
3) Local Emergency Room and Hospital costs
4) Cost of local Judicial systems
5) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.

Significant value will be given to a program that can provide services much more responsive to consumer needs with significantly reduced time frames and efficient use of limited resources!
<table>
<thead>
<tr>
<th>121990904.1.1 PASS 1</th>
<th>1.13.1 A-E</th>
<th>1.13.1 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization</th>
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</thead>
<tbody>
<tr>
<td>Camino Real Community Services</td>
<td>TPI-121990904</td>
<td>Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities</td>
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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
</tr>
<tr>
<td>P-2 Conduct mapping and gap analysis of current crisis system</td>
<td>P-3 Develop implementation plans for needed crisis services.</td>
<td>P-4 Hire and train staff to implement identified crisis stabilization services.</td>
<td>I-12 Utilization of appropriate crisis alternatives</td>
</tr>
<tr>
<td>Metric 1 P-2.1 Produce a written analysis of community needs for crisis services.</td>
<td>Metric 1: P-3.1 Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community, based on gap analysis and assessment of needs.</td>
<td>Metric 1: P4.1 Number of staff hired and trained.</td>
<td>Metric 1: I-12.1 Metric: increase in utilization of appropriate crisis alternatives.</td>
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<tr>
<td>Baseline/Goal: Produce a comprehensive report documenting all points above.</td>
<td>Baseline/Goal: At the beginning of DY 2, Crisis Stabilization Services did not exist; therefore, baseline for all is 0.</td>
<td>Baseline/Goal: Hire 75% of staff for project.</td>
<td>Baseline/Goal: By the end of DY5 the goal is for the facility to serve 108 patients.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,492,556</td>
<td>Milestone 2 Estimated Incentive Payment: $1,557,060</td>
<td>Milestone 3 Estimated Incentive Payment: $786,577</td>
<td>Milestone 5 Estimated Incentive Payment: $1,609,365</td>
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Baseline/Goal: By the end of DY4 the goal is for the facility to serve 50 patients.

Data Source:
c. Claims, encounter, and clinical record data.
d. Rationale: see project goals.

Milestone 4 Estimated Incentive Payment: $786,577

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<th>Year 2 Estimated Milestone Bundle Amount: $1,492,556</th>
<th>Year 3 Estimated Milestone Bundle Amount: $1,557,060</th>
<th>Year 4 Estimated Milestone Bundle Amount: $1,573,154</th>
<th>Year 5 Estimated Milestone Bundle Amount: $1,609,365</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,232,135
Identifying Project and Provider Information:
Title: 1.12.3 Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care: mobile clinics
Unique RHP ID#: 121990904.1.2 – PASS 2
Performing Provider: Camino Real Community Services
Performing Provider TPI: 121990904

Project Summary:
Provider Description: Camino Real Community Services is a Local Mental Health Authority that provides outpatient mental health services to child, adolescent, and adult patients with severe and persistent mental illness. The provider is located in a 10,000 square mile rural service area with a total population of approximately 206,777. In 2012, the Center provided services to 3,538 adults and children that met criteria for services. The Mental Health Operating budget is approximately 6.9 million dollars. The programs work closely with schools, health centers, hospitals, law enforcement, judiciary and local elected officials to coordinate the provision of services.

Intervention(s): The project is to establish two (2) Mobile Crisis Outreach Teams (MCOT) in the service area.

Need for the project: Camino Real Community Services’ area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible crisis interventions. The designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. There are no local psychiatric hospitals or crisis stabilization facilities in the service area. The center provided 413 crisis assessments (January 2012 – August 2012) to individuals in the service area. Of the 413 approximately 140 patients were sent to inpatient psychiatric hospitals between January 2012 – August 2012. Currently there are no Federal Funds utilized for any Mobile Crisis services in the Camino Real service area.

Target population: The target population is individuals of all ages experiencing a psychiatric crisis. The center’s current behavioral health population is comprised of individuals who are indigent (52%) or Medicaid eligible (48%). The expected patient volume this project expects to serve is as follows: DY3 100 patients, DY4 120 patients and by DY5 144 patients.

Category 1 or 2 expected patient benefits: The project intends to benefit patients by providing crisis services to individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. Services include the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance patient skills. It is the performing provider’s expectation that this model will improve access to the appropriate level of care for patients. The other benefits include decreasing travel for patients needing crisis stabilization services.

Category 3 outcomes: IT-9.2. ED appropriate utilization. Our goal is to Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse. The actual target is to be determined.
**Project Description:**

The project is to increase the capacity of its crisis services by establishing 2 Mobile Crisis Outreach Teams (MCOT) in the service area. The goal of this project is to enhance access to crisis services, while reducing the need for local Emergency Departments (ED) in Camino Real’s catchment area and reducing the number of individuals sent to more expensive mental health inpatient beds for crisis resolution services that could be provided to these individuals in a less restrictive environment.

The Camino Real Community Services area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible crisis interventions. The designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. The lack of robust social agencies or organizations geared towards addressing behavioral health crisis shifts the burden to the public community mental health system that has not been funded to develop dedicated Mobile Crisis Outreach teams in this area.

Through this project, Camino Real Community Services (CRCS) will implement clinically staffed mobile treatment teams that provide prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community. These services intend to reach individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. It is the performing provider’s expectation that this model will improve access to the appropriate level of care for patients in the provider’s service area, reduce the need for utilization of local EDs, and provide an alternate and more expedient option for law enforcement when encountering individuals in the community suffering from psychiatric disorders or experiencing a crisis. The program will also be designed to interface with CRCS’s outpatient mental health clinics to ensure that all behavioral health issues are treated in the most therapeutic manner possible.

The target goal is to decrease use of higher cost services in Emergency Rooms and/or Inpatient Facilities and get people timely access to needed services. Additional goals would be to decrease travel for patients needing crisis stabilization services. Inherent to the program design will be the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance consumer skills. This project is responsive to RHP Community Need #4.

By the end of the 5 year period and the establishment of Mobile Crisis Outreach Teams, consumers in need will be able to access these services in their community. Response times to consumers will be immediate and lead to significantly reduced wait times in emergency rooms and/or long transport times to State Hospitals and other private psychiatric facilities. The efficacy of treatment will be significantly improved and overall costs to the total care system (not just hospitals) would be significantly reduced.
**Starting Point/Baseline:**

The baseline is zero. No local 24 hour Mobile Crisis Outreach Teams exist in the community for persons who are in psychiatric crisis; persons either stay in hospital emergency rooms or are transported long distances to more restrictive inpatient service environments. The baseline will be determined in year DY3 when program is implemented.

**Rationale:**

Camino Real has selected Project **Option #1.12.3.** Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished areas of Texas. This selection is based on the fact that there are no local Mobile Crisis Outreach Teams, no local psychiatric hospitals nor local crisis stabilization services available to persons in psychiatric crisis in the Camino Real service area. The population has a significant need as evidenced by the number of calls made to the local crisis hotline and the requests made for crisis assessment at local hospitals. Development of Mobile Crisis Outreach Teams/Services offers an alternative to costly hospitalization that may occur if crisis situations escalate due to lack of immediate intervention. It is responsive to Community Need #4.

In 2008, Mental Health or Substance Abuse (MHSA) disorders were the principal reason for 1.8 million inpatient community hospital stays, accounting for 4.5 percent of stays in the U.S. This is according to Brief #117 (Agency for Healthcare Research and Quality, June 2011). It was also noted the MH and SA conditions most frequently treated in community hospitals were mood disorders (depression and bipolar disorder), schizophrenia and other psychotic disorders, alcohol-related disorders and drug-related disorders. These MHSA hospital stays cost $9.7 billion ($7.7 billion for MH; $2.1 billion for SA) accounting for 2.7 percent of all inpatient community hospital costs. Nationwide, the MH average length of stay was 8.0 days and the SA average length of stay was 4.8 days with an average cost $5100.

This project represents a significantly enhanced initiative for the Performing Provider since there are no local mobile crisis outreach teams; although, there is a 24-Hour crisis hotline available to persons in psychiatric crisis and a limited response system in place for purposes of determining recommendations for placement of persons in a more restrictive environment. Based on data reviewed from the provider’s local database the local population has a significant need as evidenced by the number of calls made to the performing provider’s crisis hotline and requests for crisis assessments by local hospitals. In Fiscal Year 2012 the center crisis hotline received 3016 calls with over 1000 of these requiring crisis assessments and 28% of those assessed needing stabilization at higher cost inpatient facilities. This results in a significant financial impact on local resources including law enforcement, judicial system and hospital emergency rooms. In addition, availability of inpatient psychiatric hospital beds in public and private facilities has been significantly reduced due to the demands of the forensic population. In Texas the average cost of an Emergency Room visit is approximately $996 and an average stay at a state funded mental health facility is $400/day according to the 2011 report by Health Management Associate on “The Impact of Proposed Budget Cuts to Community Based Mental Health Services”. Furthermore the report supports the model of community based services as a better option for treating persons with mental illness in a more cost-effective local environment. In the Texas Fact Sheet-2011 Psychiatric Hospitals there were a total of 5391 psychiatric beds in the state with 49.3% of the beds being public beds, 14.4% were nonprofit beds, and 36.3% were
for-profit beds. Two hundred and twelve counties in Texas do not have a psychiatric hospital and most hospitals are located in metropolitan areas. The Performing Provider Service area has no psychiatric hospital available; therefore, individuals in crisis do not have immediate access to a local option with regards to alternative crisis resolution services. When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail, or an inpatient hospital bed. Unfortunately, a worst case scenario occurs when even these undesirable options fail, and the consumer is left to the care of family/friends until transportation and availability of an in-patient placement can be arranged. It leaves the person in crisis and the family at great risk and feeling frustrated with the system they turn to for help.

Mobile Crisis services can be developed that create alternatives to these less desirable settings. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. A major challenge is related to the fact that the service area is vastly rural and has been designated as a Medically Underserved Area, Health Professional Shortage Area and Mental Health Shortage Area by the US Department of Health and Human Services Health Resources and Services Administration division. In the 10,000 square miles that comprise the portion of Region 6 that Camino Real is responsible for, none of the inpatient hospitals have a psychiatric unit to address the needs of the community. The lack of resources in the local community requires extensive travel into San Antonio for access to a private or public psychiatric facility in order to stabilize the person in crisis. Typically, local law enforcement provides transportation to these distant locations. The cost to the community is not only in the man hours and mileage costs associated with the transport, but the risk to the community when the peace officer is diverted from the responsibility of protecting the community to provide the needed transportation. The emotional cost to the person in crisis and their family/friends who wait for hours for logistics to be worked out in order to finally get to the help they need is immeasurable.

Citations:

Directory of Active Hospitals, 2011, Health Facility Licensing and Compliance Division, Texas Department of Stated Health Services; Hospital Tracking Database, Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services.


Related Category 3 Outcome Measure(s):
The Category 3 Outcome measure selected is OD-9, Right Care Right Setting: ED appropriate utilization. The reason for selecting this measure is that it captures the impact of having a local, cost effective alternative to higher costs systems such as jail, emergency room, or inpatient hospitalization when addressing crisis situations that can be quickly resolved. The project will track the number of persons served by the Mobile Crisis Outreach Teams and compare to historical data kept by the Center regarding the number of admissions to public and private in-patient psychiatric institutions to calculate cost avoidance. As the community becomes familiar with the MCOT services and these teams divert persons in psychiatric crisis from the jails, Emergency Room, and inpatient hospitals, data will be tracked and calculation of cost avoidance to the ER and jails will be maintained to substantiate the cost effectiveness of this alternative.

Health Management Associates, in their March 2011 Impact of Proposed Budget Cuts to Community-Based Mental Health Services presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is $12 for adults and $13 for children, as compared to $401 for a State Hospital bed, $137 for a jail bed for an inmate with mental illness, and $986 for an emergency room visit. Camino Real anticipates that development of a mobile crisis outreach teams in the local community will also reduce costs to other stakeholders involved in the crisis response system which includes the local sheriff’s department and the judicial system.

Relationship to other Projects:
Camino Real is proposing one other project in Region 6. It is category 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization with Quality Improvement 3.IT-9.4 Right Care, Right Setting. The unique RHP # is 121990904.1.1

The proposed project for the development of Mobile Crisis Outreach Teams compliments the proposal for development of crisis stabilization services and allows for a strong continuum of care in the most cost effective environments.

It relates to other projects in the region by addressing the need for a local alternative for stabilization of crisis situations that are benign and are more appropriately addressed in a facility located within the service area. Hospital emergency rooms, law enforcement personnel, jails, programs of the center and other affiliated agencies will have the capability to place individuals in this facility. This project will compliment other activities and will be a clear alternative to options that are costly, involve extended wait times for consumers, use great amounts of local resources and involve long travel distances for people that are needing services.

Relationship to Other Performing Providers’ Projects in the RHP:
NON APPLICABLE

Plan for Learning Collaborative:
NON APPLICABLE
# Project Valuation:

Highest cost for stabilization services occur when crises escalate and require an inpatient/institutional solution due to lack of options in the local community. Mobile Crisis Outreach services create immediate alternatives to individuals who are in a mental health crisis and otherwise may be responded to by local Law Enforcement and taken to Emergency Departments. Cost avoidance is the basis for development of crisis mobile outreach teams in this region.

This project valuation has taken into consideration:
1) Costs for both State operated and private Psychiatric Hospitals: **EXAMPLE:** $5,100 (avg. inpatient cost) X 100 individuals = $510,000 per year
2) Costs of Local Emergency Department Visits: **EXAMPLE:** $996 ED cost X 100 individuals = $99,600 per year
3) Cost of local Judicial systems
4) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.

The implementation of a local mobile crisis outreach teams will result in significant cost savings to various entities locally and at the state and federal levels through basic cost avoidance. Health Management Associates, in their March 2011 *Impact of Proposed Budget Cuts to Community-Based Mental Health Services* presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is $12 for adults and $13 for children, as compared to $401 for a State Hospital bed, $137 for a jail bed for an inmate with mental illness, and $986 for an emergency room visit. This project will produce the outcomes desired in a transformation initiative!
<table>
<thead>
<tr>
<th>Category 3 Outcome Measure:</th>
<th>121990904.3.2</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization (Standalone measure) Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Metric 1:</strong> P-2 Identify licenses, equipment requirements and other components needed to implement and operate options selected.</td>
<td><strong>Metric 1:</strong> P-3 Develop administrative protocols and clinical guidelines for project selected.</td>
<td><strong>Metric 1:</strong> I-11.1 20% increase over DY 4 utilization of community behavioral healthcare services.</td>
<td><strong>Metric 1:</strong> I-11.1 20% increase over DY 4 utilization of community behavioral healthcare services.</td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
</tr>
<tr>
<td>P-2 Identify licenses, equipment requirements and other components needed to implement and operate options selected.</td>
<td>P-3 Develop administrative protocols and clinical guidelines for project selected.</td>
<td>I-11 Increased utilization of community behavioral healthcare.</td>
<td>I-11 Increased utilization of community behavioral healthcare.</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> P-2.1 Develop a project plan and timeline detailing the operational needs, training materials, equipment and component. Baseline: Baseline is zero. Goal: Submission of Project Plan</td>
<td>Metric 1: P-3.1 Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline: Baseline is zero. Goal: Submission of manual of operations</td>
<td>Metric 1: I-11.1 20% over DY 3 increase utilization of community behavioral healthcare services. Goal: The number of persons served will be increased by 20% over DY 3 or a minimum of 120 persons served.</td>
<td>Metric 1: I-11.1 20% increase over DY 4 utilization of community behavioral healthcare services. Goal: The number of persons served will be increased by 20% over DY4 or a minimum of 144 persons served.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Administrative protocols; Clinical guidelines</td>
<td><strong>Data Source:</strong> Administrative protocols; Clinical guidelines</td>
<td><strong>Data Source:</strong> Claims data an encounter data from community behavioral health sites and expanded transportation programs.</td>
<td><strong>Data Source:</strong> Claims data an encounter data from community behavioral health sites and expanded transportation programs.</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $198,743</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $207,650</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $210,54</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $215,125</td>
</tr>
</tbody>
</table>
| Milestone 2                  | transportation and/or mobile clinic options | Metric P-5.1. Number of areas prioritized for intervention with options in operation  
|                            |                                           | a. Number of patients served in these options  
| Baseline: Baseline is zero  |                                           | Baseline: Baseline is zero  
| Goal: 4 Staff will be hired and one MCOT established. | Goal: Additional 4 staff hired, two MCOTs established/maintained & 100 persons served. | Data Source: Client Data records  
| Data Source: a. Project records; Training curricula as develop in P-2 | Milestone 4 Estimated Incentive Payment: $207,650 | Milestone 6 Estimated Incentive Payment: $210,541  
|                             | Year 2 Estimated Milestone Bundle Amount: $397,486 | Year 3 Estimated Milestone Bundle Amount: $415,300  
|                             | Year 4 Estimated Milestone Bundle Amount: $421,081 | Year 5 Estimated Milestone Bundle Amount: $430,250  

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,664,117
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Bexar CARES for Children: Crisis and Respite Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 137251808.1.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services</td>
</tr>
<tr>
<td>Performing Provider TPI: 137251808</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider Description:** Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

**Intervention(s):** CHCS seeks to establish a residential crisis and respite center for children with severe emotional disturbance that will include a total of 16 beds, eight reserved for children in crisis and eight for children whose families require a brief respite from the overwhelming, 24-hour per day responsibilities of delivering care. The availability of this new community resource will enable children to reach and maintain their highest level of functioning while minimizing further crisis and hospitalization. In the crisis service component, children will receive comprehensive psychiatric assessment and treatment as needed to restore stability as well as residential care, e.g., meals, nursing care, etc. Children in the respite care service component will receive residential care, psychiatric treatment and support as needed. A primary care physician will be available to conduct routine diagnostic work ups and check for developmental disabilities and other co-occurring conditions. When appropriate, children served in either the crisis or respite components will be connected to community based outpatient care through CHCS’ Children’s Mental Health Services program and/or Early Childhood Intervention services. The assignment of Family Partners from CHCS will be a critical ingredient to the success of this approach as they have the experience and empathy required to effectively connect families to resources and support positive parenting and decision-making.

**Need for the project:** Children with serious emotional disturbance, especially those involved with multiple systems (juvenile probation, schools, child welfare), and those with developmental disabilities and delays (including those where those disabilities or delays are attributed to their mothers use of substances while they were in utero) often experience periods of crisis and require specialized supports if they are to regain stability and avert longer-term placement. The significant requirements of delivering care to these children can be draining to their families and can result in inadequate care or even abuse or neglect. Bexar County does not currently have a facility designed to deliver needed supports to children in crisis or their families.

**Target population:** Children with serious emotional disturbance. Based upon current service statistics, it is anticipated that 44% will be indigent and uninsured and 46% will be covered by Medicaid.

**Category 1 or 2 expected patient benefits:** The project seeks to realize an increase in the utilization of appropriate crisis and respite alternatives in DY4 and in DY5. The project plans to serve 100 children in its first full year of operation (DY4) and 150 in DY5, a 50% increase. Significant cost savings will result from community-based care in lieu of
inpatient or emergency care as well as better ED appropriate utilization. 

**Category 3 outcomes:** IT-9.2 Our first goal is to achieve an improvement, in appropriate utilization of crisis services. IT-5.1 Our second goal is to achieve a 5% cost savings as a direct result of efficient care delivery.

**Project Description:**

The Center for Health Care Services (CHCS) seeks to establish a residential crisis and respite center for children with severe emotional disturbance. The center would include a total of 16 beds, eight reserved for children in crisis and eight for children whose families require a brief respite from the overwhelming, 24-hour per day responsibilities of delivering care. The availability of this new community resource will enable children to reach and maintain their highest level of functioning while minimizing further crisis and hospitalization. Children in the crisis service component will receive comprehensive psychiatric assessment and treatment as needed to restore stability as well as residential care, e.g., meals, nursing care, etc. Children in the respite care service component will receive residential care, psychiatric treatment and support as needed. A primary care physician will be available to conduct routine diagnostic work ups and check for developmental disabilities and other co-occurring conditions. When developmental disabilities are diagnosed, the child also will be connected to the Early Childhood Intervention program. Finally, all children served in either the crisis or respite components will be connected to community based outpatient care through CHCS’ Children’s Mental Health Services program. The assignment of Family Partners to families accessing services from the center will be a critical ingredient to the success of this approach as they have the experience and empathy required to effectively connect families to resources and support positive parenting and decision-making.

Another critical component of the new program will be the availability of comprehensive assessment services. Evidence-based pediatric diagnostic tools will be used to develop a precise diagnosis and to advise the types of services that will benefit the child, e.g., residential placement or outpatient care. It is anticipated that the new center will meet a wide variety of needs ranging from children in active crisis who may or may not have a psychiatric diagnosis to those who are leaving longer-term hospitalization and require step-down care or to families who need a break from their child’s care requirements. The availability of this new resource also is expected to divert children from further involvement with or referral to Bexar County Juvenile Probation or Child Protective Services.

**Goals.** Establish a single location offering a continuum of care for children with acute or chronically severe behavioral health needs. Use the center as a site for training staff from a variety of disciplines to increase the availability of pediatric specialists with behavioral health competencies.

**Challenges addressed by the project.** Children with serious emotional disturbance, especially those involved with multiple systems (juvenile probation, schools, child welfare), and those with developmental disabilities and delays (including those where those disabilities or delays are attributed to their mothers use of substances while they were in utero) often experience periods of crisis and require specialized supports if they are to regain stability and avert longer-term placement. The significant requirements of delivering care to these children can be draining to their families and can result in inadequate care or even abuse or neglect. Bexar County does not currently have a facility
designed to deliver needed supports to children in crisis or their families.

5-year expected outcomes for CHCS. 1) Development of Residential Crisis/Respite Center for Children and Adolescents in Bexar County. 2) Expanded hours of operation for crisis services. 3) Expanded respite home providers.

5-year expected outcomes for persons served by the project. 1) Improved access and availability to crisis services for children and adolescents through extended hours of operation for nights/weekends. 2) Reduced waiting time during a psychiatric crisis. 3) Reduced inpatient admissions for children and adolescents in crisis. 4) Diversion from referrals to juvenile justice and child welfare for children and adolescents with behavioral health issues during a psychiatric crisis.

Relation to Regional Goals. As there are no similar services available to Bexar County children and their families, the proposed Bexar CARES Crisis and Respite Center will support the regional goal of “Improving the infrastructure for delivery of behavioral health services”. It also meets the CMS three part aim, by improving population care with increased patient satisfaction by filling an existing gap in care and improving the existing behavioral health infrastructure to better serve Medicaid and uninsured children in Bexar County in individualized and patient centered settings. The program offers step down care for children discharged from hospitals and establishes a coordinated care delivery system and step-down care. D) The program will reduce hospital re-admissions, which will improve outcomes while containing cost growth.

Starting Point/Baseline:
This is a new project. There are currently 0 clients served. However, the Children’s Mobile Outreach Team (CMOT) responded to 615 crisis calls for children during the last nine months of Program Year 2012.

Rationale:
The project option (1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system), process milestone (P-3 Develop implementation plans for needed crisis services and P-6 Evaluate and continuously improve crisis services) and improvement milestone (I-12 Utilization of appropriate crisis alternatives) were selected in correspondence to existing, unmet community needs for children’s crisis and respite services. The current service continuum for children does not include either crisis or respite care services, both of which are known to prevent re-admission. This project builds upon existing and planned behavioral health system enhancements and will assist Bexar County in developing crisis alternatives, which will reduce utilization of emergency departments and preventable inpatient stays.

Project Components: Through the development of the Crisis stabilization unit we propose to meet all required project components. a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service. c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crisis in community-based settings. By developing this crisis
stabilization unit dedicated to children and adolescents. We will be able to baseline and assess health needs and begin to set up a system for delivery of care and determine needed types and volume of services. d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. Although there are no similar services in this community we will explore other models offered throughout the country. e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s) including special considerations for safety-net populations. With this being a new service we will be able to assess barriers, risks, and opportunities and document this as lessons learned whereby implementing necessary changes to ensure access and quality of services are maximized.

**Unique community need identification numbers the project addresses:**
- CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

The proposed project will positively impact issues identified by University Health System as the Mental and Behavioral Health Unique needs identification numbers: 1. Inadequate and fragmented continuum of care for children with behavioral health diagnoses. 2) Inadequate access to care management and resource navigation. 3) How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: New initiative.

Related initiatives funded by U.S. Department of HHS. None.

**Related Category 3 Outcome Measure(s):**
- OD-9 Right Care, Right Setting
- IT-9.2 ED appropriate utilization
- 1) OD-5 Cost of care, IT-5.1 Improved cost savings: demonstrate cost savings in care delivery.

**Reasons/rationale for selecting the outcome measures:**
These measures are indicative of children finding the right care in an easily accessed setting, which will diminish crises, improve behavioral health status, reduce the inappropriate use of emergency departments and reduce cost of care.

**Relationship to other Projects:**
There is one related project proposed for implementation in RHP 6: establishment of a children’s mental health emergency room in Bexar County (1.12). It is unclear whether this is a supportive service for the Crisis Respite Center. A new treatment project for children with ADHD is being proposed for RHP 6 (2.15). Because the Crisis Respite Center will include services for children with both a serious emotional disturbance and a developmental disability, it is possible that the children served in the new ADHD project will also receive services from the Crisis Respite Center. CHCS will coordinate service availability and innovative ways of meeting the shared target population’s needs with the Performing Provider.
**Relationship to Other Performing Providers’ Projects in the RHP:**

Clarity is proposing establishment of the Children’s Mental Health Emergency Room. CHCS will join Clarity in any University Health System-organized learning collaborative dedicated to sharing best practices and service solutions for children’s mental health. If there is a collaboration opportunity with the ADHD project proposed by UTHSCSA, CHCS will join key UTHSCSA staff in any learning community organized by University Health System.

**Plan for Learning Collaborative:**

CHCS will participate in any and all relevant learning collaborative organized by University Health System.

**Project Valuation:**

The value for this project is $1,998,596 for DY 2 and $8,809,554 for all years. By DY5, the project proposes to serve 150 children in community-based crisis and respite care. The establishment of a Children’s Crisis Respite Center fills an existing gap in the local continuum of behavioral health care for children. The availability of this new resource will ensure children in a behavioral health crisis are stabilized, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments as well as providing respite for them and their families to prevent destabilization. This also will be a critical resource and a new option for police departments, schools and child protective services, making it an alternative to more costly and restrictive institutional care. CHCS has a significant amount of existing infrastructure from which this project can be launched; only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs...
averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of a dedicated Children’s Crisis Respite Center has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.1.1</th>
<th>1.13.1</th>
<th>1.13.1.a-e</th>
<th>13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Children’s Crisis Respite Center</th>
</tr>
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<tbody>
<tr>
<td>PASS 1</td>
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<tr>
<td>Center for Health Care Services</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>137251808.3.1</td>
<td>3.IT-5.1 &amp; IT-9.2</td>
<td>Improved cost savings: demonstrate cost savings in care delivery AND ED appropriate utilization</td>
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<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>P-3 Develop implementation plans for needed crisis services</td>
<td>P-6 Evaluate and continuously improve crisis services</td>
<td>I-12: Utilization of appropriate crisis alternatives.</td>
<td>I-12: Utilization of appropriate crisis alternatives.</td>
</tr>
<tr>
<td>Metric 1 P-3.1: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. Baseline/Goal: Produce one written plan Data Source: Written Plan</td>
<td>Metric 2 P-6.1: Project planning and implementation documentation demonstrates play, do, study, act quality improvement cycles. Baseline/Goal: Plan Do Study act methodology used for project implementation and improvement cycle. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement and improvement milestone.</td>
<td>Metric 1 I-12.1: % increase in utilization of appropriate crisis alternatives. Goal: 100 children served in community-based crisis or respite care. Data Source: Clinical records.</td>
<td>Metric 1 I-12.1: % increase in appropriate crisis alternatives. Goal: 150 children served in community-based crisis or respite care. Data Source: Clinical records.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,998,596</td>
<td>Milestone 2 Estimated Incentive Payment: $2,194,705</td>
<td>Milestone 3 Estimated Incentive Payment: $2,347,824</td>
<td>Milestone 4 Estimated Incentive Payment: $2,268,429</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,998,596</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,194,705</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,347,824</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,268,429</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,809,554**
Identifying Project and Provider Information:

Title: 1.12.1 Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based setting in areas of the State where access to care is likely to be limited: Expanded OP Capacity
Unique RHP ID#: 137251808.1.2 – PASS 1
Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services
Performing Provider TPI: 137251808

Project Summary:

Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

Intervention(s): The Center For Health Care Services (CHCS) seeks to expand access to mental health services in Bexar County. This will include: new clinical locations, longer service hours and evening and weekend coverage at new and existing locations; utilization of a behavioral health care manager model to align case management and wellness education with treatment services to more rapidly improve outcomes; and increased training opportunities to support the expanded workforce needs. Telemedicine will be used in the near term to augment the available behavioral health workforce until such time as the number of skilled clinicians increases. Finally, a Psychiatric Urgent Care Clinic will be opened to dispense medications and connect consumers in crisis to durable community-based care. Services available from the clinics will include psychiatry, labs and medication, mental health treatment ancillary to psychiatric care, peer recovery services, and substance abuse counseling and treatment for individuals with co-occurring disorders. All new facilities will be located in Mental Health Professional Shortage Areas, per the U.S. Health Resources and Services Administration. This project is in direct response to significant gaps identified in community needs assessments and other planning documents that have verified the insufficiency of outpatient care for the target population. Improved access to care reduces symptomology and crises and improves functioning, which are known correlates to improved quality of life, greater retention in and compliance with care recommendations, and cost reductions attributable to unnecessary utilization of acute and sub-acute services.

Need for the project: Resource limitations for outpatient psychiatric care in Bexar County, triggered by state funding cuts, have greatly diminished access to needed services, especially for persons with severe and persistent mental illness, the elderly and adults with co-occurring mental illness and substance abuse disorders. Also, state funds must only be used for priority populations, i.e., persons diagnosed with severe depression, schizophrenia or bi-polar disorder. Individuals with diagnoses that do not meet one of these classifications, e.g., major depression, anxiety disorders, post-traumatic stress disorder, are forced to wait for care and, when their symptoms escalate beyond their capacity for self-management, most are reliant upon urgent or acute care from the most costly providers, e.g., emergency departments, hospitals. Many of these individuals cannot maintain their stability through available resources and do not get their medications refilled or managed in a consistent manner, further triggering decompensation and the need for acute care.

Target population: Adults with severe and persistent mental illness, substance abuse
disorders and/or co-occurring disorders. Based upon current service statistics, it is anticipated that 46% of those served will be indigent and uninsured and 50% will be covered by Medicaid.

**Category 1 or 2 expected patient benefits:** The project seeks to realize a 20% increase or 7,002 individuals from a baseline of 5,835 in the utilization of community behavioral health care services in DY4, and a 30% or 1,750 increase in DY5 with an overall goal of 7,585 utilizing community behavioral healthcare.

**Category 3 outcomes:** IT-10.1. Our goal is to demonstrate improvement in quality of life (QOL) scores for DYs 4 and 5.

### Project Description:

The Center For Health Care Services (CHCS) seeks to expand access to mental health services in Bexar County. This will include both new clinical locations, longer service hours and evening and weekend coverage at new and existing locations, utilization of a behavioral health care manager model to align case management and wellness education with treatment services to more rapidly improve outcomes, and increased training opportunities to support the expanded workforce needs. Also, telemedicine will be used in the near term to augment the available behavioral health workforce until such time as the number of skilled clinicians increases. Finally, a Psychiatric Urgent Care Clinic will be opened to dispense medications and connect consumers in crisis to durable community-based care. Services available from the clinics will include psychiatry, labs and medication, mental health treatment ancillary to psychiatric care, peer recovery services, and substance abuse counseling and treatment for individuals with co-occurring disorders. All new facilities will be located in Mental Health Professional Shortage Areas, per the U.S. Health Resources and Services Administration.

**Goals.** Improve access to behavioral health care and reduce unnecessary hospitalizations resulting from lengthy waiting lists for care. Increase utilization of community behavioral health services, reducing inappropriate use significantly more costly care, i.e., institutional and crisis care.

**Challenges addressed by the project.** Resource limitations for outpatient psychiatric care in Bexar County, triggered by state funding cuts, have greatly diminished access to needed services, especially for persons with severe and persistent mental illness, the elderly and adults with co-occurring mental illness and substance abuse disorders. Also, state funds must only be used for priority populations, i.e., persons diagnosed with severe depression, schizophrenia or bi-polar disorder. Individuals with diagnoses that do not meet one of these classifications, e.g., major depression, anxiety disorders, post-traumatic stress disorder, are forced to wait for care and, when their symptoms escalate beyond their capacity for self-management, most are reliant upon urgent or acute care from the most costly providers, e.g., emergency departments, hospitals. Many of these individuals cannot maintain their stability through available resources and do not get their medications refilled or managed in a consistent manner, further triggering de-compensation and the need for acute care.

**5-year expected outcomes for CHCS.**

1) New outpatient clinic site developed in downtown the San Antonio "Corridor of Care" offering integrated behavioral and primary health care. 2) New urgent care medication management clinic services. 3) Expanded hours access for psychiatric and related clinical services to include evenings and weekends.
5-year expected outcomes for persons served by the project.
Improved access to services, including: a) Significantly reduced waiting time for physician appointments. Currently, new psychiatric evaluation appointments are scheduled 10-14 weeks from date of intake. Reduced waiting times will improve patient satisfaction and reduce adverse outcomes caused by the lack of timely access to care. b) Improve compliance with scheduled appointments. The new availability of evening and weekend hours will support consumers in keeping appointments and accessing routine care. c) Urgent care for medication management and related crisis resolution.

Relation to Regional Goals. Expanding resource availability to address the dearth of outpatient mental health services is a key means of achieving the regional goal of “Improving the infrastructure for delivery of behavioral health services”. It also meets the CMS three part aim, as follows. 1) The program fills an existing gap in care and improves the existing behavioral health infrastructure to better serve Medicaid and uninsured adults in Bexar County. 2) The program will support lasting community living and reduce hospital re-admissions, which will improve outcomes while containing cost growth.

Starting Point/Baseline:
The baseline for the proposed project is the number of adults served in CHCS’ existing adult outpatient clinics (Harvard Place, Zarzamora, Northwest) in FY 2012, or 5,835.

Rationale:
The project option (1.12.1 Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based setting in areas of the State where access to care is likely to be limited Expand the number of community based settings where behavioral health services may be delivered in underserved areas), process milestones (P-3 Develop administrative protocols and clinical guidelines for projects selected and P-6 Establish behavioral health services in new community-based settings in underserved areas) and improvement milestone (I-11 Increased utilization of community behavioral healthcare) were selected in correspondence to existing, unmet community needs for outpatient care and treatment. Positive behavioral health outcomes are contingent upon the availability of the consumer to obtain services as soon as possible after a need has been identified. However, adults with mental illnesses who are reliant upon public mental health services often face significant wait times before they can access care, e.g., the wait for a psychiatric examination currently averages 14 weeks. Waiting for care can be especially detrimental to the target population, who may be easily discouraged and opt out of care seeking, worsening symptoms and heightening functional loss.

The project also seeks to expand the availability of appropriate, credentialed mental health professionals to provide optimal treatment to the target population. A March 2011 report published by the Hogg Foundation for Mental Health and Methodist Healthcare Ministries warns the most severe health profession shortages are in mental health services, with Texas ranking far below the national average in number of mental health professional per 100,000 residents. Further, less than 33% of the state’s 48,700 practicing doctors accept Medicaid patients and nearly every county in RHP 6 is designated as a
Health Provider Shortage Area for mental health. Inadequate mental health services results in avoidable costs to hospital and criminal and juvenile justice systems.47

**Project Components:** Through expansion of outpatient capacity, we propose to meet all required project components. a) Evaluate existing transportation programs and ensure that transportation to and from medical appointments is made available outside of normal operating hours. If transportation is a significant issue in care access, develop and implement improvements as part of larger project. b) Review the intervention(s) impact on access to behavioral health services and identify “lessons learned” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

**Unique community need identification numbers the project addresses:**
- CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

More specifically, the proposed project will also positively impact the following:
1. Inadequate access to care management and resource navigation
2. Inadequate services for individuals who have been arrested or incarcerated either as a result or precipitated by unmet behavioral health needs
3. Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders
4. Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments

How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: Significant enhancement. Currently, our outpatient clinics are limited in location and hours. The initiative will improve access, reduce wait times and provide services where access to care is currently limited. As more adults are stabilized through consistent, timely outpatient care, their use of inappropriate crisis services, i.e., emergency departments, will decrease.

Related initiatives funded by U.S. Department of HHS. The Outpatient Clinics currently receive funding from HHS, via Texas Department of State Health Services for Adult Outpatient Services.

**Related Category 3 Outcome Measure(s):**

OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life.

**Reasons/rationale for selecting the outcome measures:** This measure is indicative of consumer retention in care and enhanced stability, both of which are critical means of reducing unnecessary hospitalizations and the inappropriate use of emergency departments.


569 ★ RHP 6 Plan ★ March 8, 2013 Center for Health Care Services
Relationship to other Projects:
The proposed project will address significant behavioral health care resource insufficiency in Bexar County. As such, it is an integral component of this County’s health care infrastructure. Another proposed project seeks to establish research-based care for a segment of the population of adults with mental illness. These resources will be coordinated with CHCS’s proposed outpatient expansion, if appropriate, to build a more durable continuum of care.

Relationship to Other Performing Providers’ Projects in the RHP:
UTHSCA is proposing a potentially similar project. CHCS will join any collaborative learning communities with UTHSCA or other providers dedicated to serving adults with mental illness.

Plan for Learning Collaborative:
CHCS will participate in any and all relevant learning collaboratives organized by University Health System.

Project Valuation:
The value for this project is $3,997,191 for DY 2 and $17,619,107 for all years. By DY5, 7,585 adults with serious mental illness will receive outpatient behavioral health services every year. The expansion of Adult Outpatient Services will increase accessibility of behavioral health care and will ensure expedient treatment and rapid connection to systems of care that support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs.
averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of expanded Adult Outpatient Mental Health Services has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.1.2 PASS 1</th>
<th>1.12.1</th>
<th>1.12.1.A-B</th>
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<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Quality of Life</strong></td>
</tr>
<tr>
<td>1.12.1.1</td>
<td>1.12.1.2</td>
<td>1.12.1.3</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
</tr>
<tr>
<td>P-3: Develop administrative protocols and clinical guidelines for projects selected. Metric 1 P-3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines. Baseline/Goal: Manual completed Data Source: Administrative protocols</td>
<td>P-6: Establish behavioral health services in new community-based settings in underserved areas. Metric 1 6.1: Number of new community based settings where behavioral health services are delivered Baseline/Goal: One new clinic in an underserved area; one expanded clinic in a high volume and/or underserved area. Data Source: Number of new or expanded clinics in operation</td>
<td>I-11: Increased utilization of community behavioral healthcare Metric 1 I-11.1: % utilization of community behavioral health care services Baseline: 5,835 (DY3) Goal: 7,002 or 20% increase Data Source: Claims and encounter data.</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,997,191</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,389,410</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,695,648</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $17,619,107</strong></td>
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</table>
**Identifying Project and Provider Information:**

| Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Transitional Residential Services |
| Unique RHP ID#: 137251808.1.3 – PASS 1 |
| Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services |
| Performing Provider TPI: 137251808 |

**Project Summary:**

Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

**Intervention(s):** The Center For Health Care Services (CHCS) seeks to establish crisis transitional residential options, up to 32 beds, for adults. Available service will include: 1) crisis respite and a continuum of care (e.g., psychiatric care, medication management, nursing services, intensive case management, peer support) for individuals with complex treatment issues, including those who are chronically mentally ill, homeless and alcohol or drug dependent and have chronic medical conditions; and, 2) transitional residential services, including medication assistance, support for activities of daily living and connection to supported housing and employment services, to assist individuals with complex treatment issues move to greater independence and community living. These new resources will provide the most appropriate, least restrictive care and are cost effective alternatives to longer-term hospitalization (on the front end) or subsequent, rapid re-hospitalization. The variety of available service options will enable individualized care in correspondence to patient needs.

**Need for the project:** Following crisis stabilization, adults with persistent mental illness often benefit from transitional or step-down care designed to support their effective adjustment to community living. There are no such resources in Bexar County, thereby hindering successful community reintegration and increasing the potential for cycling back into costly inpatient care.

**Target population:** Adults with persistent mental illness. Based upon current service statistics, it is anticipated that 21% will be covered by Medicaid and 58% will be indigent and uninsured.

**Category 1 or 2 expected patient benefits:** The project seeks to realize a 20% increase or 270 individuals from a baseline of 1,353 in the utilization of appropriate crisis alternatives in DY4 and a 35% or a 475 increase in DY 5 that will access appropriate crisis care through the unit.

**Category 3 outcomes:** IT-3.8 Our goal for reducing the behavioral health/substance abuse 30-day re-admission rate will be determined in DY4.

**Project Description:**

The Center For Health Care Services (CHCS) seeks to establish crisis transitional residential options, up to 32 beds, for adults. Available service will include: 1) crisis respite care and a continuum of services (e.g., psychiatric care, medication management, nursing services, intensive case management, peer support) for individuals with complex treatment issues, including those who are chronically mentally ill, homeless and alcohol or drug dependent and have chronic medical conditions; and, 2) transitional residential services, including medication assistance, support for activities of daily living and
connection to supported housing employment services, to assist individuals with complex
treatment issues move to greater independence and community living. These new
resources will provide the most appropriate, least restrictive care and are cost effective
alternatives to longer-term hospitalization (on the front end) or subsequent, rapid re-
hospitalization. The variety of available service options will enable individualized care in
correspondence to patient needs.

The Crisis Transitional Residential Services approach meets an identified need for high
acuity, secure beds and will enable the more efficient use of scarce inpatient psychiatric
care. Special, high-risk populations, e.g., sex offenders, ex-offenders, could be assisted
without compromising public safety.

Goals: Reduce the per capita cost of care and improve health outcomes, including
lengthening time spent living productively in the community, of patients with significant
behavioral health needs and frequent hospitalizations. Reduce potential hospital
readmissions among a targeted post-acute population.

Challenges addressed by the project. Following crisis stabilization, adults with persistent
mental illness often benefit from transitional or step-down care designed to support their
effective adjustment to community living. There are no such resources in Bexar County,
thereby hindering successful community reintegration and increasing the potential for
cycling back into costly inpatient care.

5-year expected outcomes for CHCS. 1) Development of new Crisis Transitional Services
for adults in Bexar County. 2) Expanded hours of operation for crisis services. 3)
Expanded crisis transitional options.

5-year expected outcomes for persons served by the project. The proposed new
alternative crisis services will expand opportunities available to individuals with serious
mental illness, increasing the number accessing appropriate care by 35% in DY5.

Accessing appropriate care will improve treatment compliance and retention in care and
will support a stronger, more durable transition into the community after extended
hospitalization. Other related outcomes include: 1) Improved access and availability to
crisis services for adults through extended hours of operation for nights/weekends and
assistance with crisis transportation. 2) Reduced waiting time during a psychiatric crisis.
3) Reduced potentially avoidable re-admissions for adults. 4) Diversion from emergency
departments. 5) Availability of new step-down care.

Relation to Regional Goals. As there are no similar services available to Bexar County
residents, the proposed Crisis Transitional Residential Services support the regional goal
of “Improving the infrastructure for delivery of behavioral health services”. It also meets
the CMS three part aim, as follows.

- The program enables and ensures individualized, patient-centered care.
- The program fills an existing gap in care and improves the existing behavioral
  health infrastructure to better serve Medicaid and uninsured adults in Bexar
  County.
- The program offers step down care for individuals discharged from hospitals and
  supports their re-integration into daily living, thereby establishing a coordinated
  care delivery system.
- The program will support lasting community living and reduce hospital re-
  admissions, which will improve outcomes while containing cost growth.
## Starting Point/Baseline:
CHCS currently operates a 16-bed crisis transitional unit. The proposed facility and project will serve a different and more complex target population.

## Rationale:
The project option (1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system), process milestone (P-3 Develop implementation plans for needed crisis services and P-6 Evaluate and continuously improve crisis services) and improvement milestone (I-12 Utilization of appropriate crisis alternatives) were selected in correspondence to existing, unmet community needs for crisis services. Specifically, the crisis continuum does not contain after-care or step-down services that are known to support community re-integration or assimilation post-hospitalization and prevent re-admission. This project builds upon existing and planned behavioral health system enhancements and will assist Bexar County in developing crisis alternatives, which will reduce utilization of emergency departments and preventable inpatient stays.

### Project Components:
Through the Crisis Transitional Residential Services, we propose to meet all required project components. a) Convene community stakeholder who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service. c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crisis in community-based settings. By developing this crisis stabilization unit dedicated to children and adolescents. We will be able to baseline and assess health needs and begin to set up a system for delivery of care and determine needed types and volume of services. d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. Although there are no similar services in this community we will explore other models offered throughout the country. e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s) including special considerations for safety-net populations. With this being a new service we will be able to assess barriers, risks, and opportunities and document this as lessons learned whereby implementing necessary changes to ensure access and quality of services are maximized.

Unique community need identification numbers the project addresses:
- CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.
More specifically, the proposed project will positively impact the following issues:
1. Inadequate access to care management and resource navigation
2. Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders
3. Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments

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

Related initiatives funded by U.S. Department of HHS. None.

### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>OD-3 Potentially Preventable Re-admissions</th>
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<tr>
<td>IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate.</td>
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</table>

Reasons/rationale for selecting the outcome measures:
This measure is indicative of adults finding the right care in an easily accessed setting, which will diminish crises, improve behavioral health status, reduce the inappropriate use of emergency departments and reduce cost of care.

### Relationship to other Projects:
There are no similar services proposed in RHP 6. As such, the Crisis Transitional Residential Services project will fill a critical gap in Bexar County’s behavioral health continuum of care.

### Relationship to Other Performing Providers’ Projects in the RHP:
There are no similar projects proposed.

### Plan for Learning Collaborative:
CHCS will participate in any and all relevant learning collaborative organized by University Health System.

### Project Valuation:
The value for this project is $1,598,877 for DY 2 and $7,047,642 for all years. By DY5, 475 adults will receive appropriate crisis care each year from the proposed project. The establishment of a Crisis Transitional Residential Services program fills an existing gap in the local continuum of behavioral health care for adults with mental illness. The availability of this new resource will ensure the target population of high need adults is stabilized, connected to continuity care to support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched; only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered
several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of a dedicated Crisis Transitional Unit will provide a cost effective alternative to current over-reliance on emergency departments and providers of tertiary care and also has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.1.3</th>
<th>1.13.1</th>
<th>1.13.1.a-e</th>
<th>DEPEND AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: CRISIS TRANSITIONAL RESIDENTIAL SERVICES</th>
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<td>3.1T-3.8</td>
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<tr>
<td>Center for Health Care Services</td>
<td>TPI - 137251808</td>
<td>Behavioral Health/Substance Abuse 30 Day Readmission Rate</td>
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<tr>
<th>Related Category 3 Outcome Measure(s): OD-3</th>
<th>137251808.3.4</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>Milestone 1</td>
<td>P-3 Develop implementation plans for needed crisis services Metric P-3.1 Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based upon gap analysis and assessment of needs. Goal: Written plan Data Source: Written plan</td>
<td>Milestone 2</td>
<td>P-6 Evaluate and continuously improve crisis services Metric 1 P-6.1: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Goal: CQI report and corresponding program operational changes (if indicated in the CQI report) Data Source: CQI reports</td>
<td>Milestone 3</td>
<td>I-12: Utilization of appropriate crisis alternatives. Metric 1 I-12.1: % increase in utilization of appropriate crisis alternatives. Baseline: 1,353 adults in need of appropriate crisis alternatives Goal: 270 or 20% of baseline will access appropriate crisis care through the Unit Data Source: Clinical records.</td>
</tr>
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</table>

| Milestone 1 Estimated Incentive Payment: $1,598,877 | Milestone 2 Estimated Incentive Payment: $1,755,764 | Milestone 3 Estimated Incentive Payment: $1,878,259 | Milestone 4 Estimated Incentive Payment: $1,814,742 |

| Year 2 Estimated Milestone Bundle Amount: $1,598,877 | Year 3 Estimated Milestone Bundle Amount: $1,755,764 | Year 4 Estimated Milestone Bundle Amount: $1,878,259 | Year 5 Estimated Milestone Bundle Amount: $1,814,742 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,047,642
Identifying Project and Provider Information:

Title: 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Children's Mental Health
Unique RHP ID#:137251808.1.4 – PASS 1
Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services
Performing Provider TPI: 137251808

Project Summary:

Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

Intervention(s): The Center For Health Care Services (CHCS) seeks to establish a centralized, accessible campus from which systems or families can obtain care for children and adolescents (0 to 17 years old) with a serious emotional and/or behavioral problem or developmental delays. Services will include: comprehensive treatment planning, wraparound care, mental health interventions, coordination of care among all interested systems (schools, juvenile justice, child protective services), substance abuse counseling, group counseling for children, parents or caregivers and siblings, recreational therapy, ROPES course, connection to in-home services (occupational therapy, physical therapy, nutritional counseling, medication education, in-home nursing care), therapeutic foster care, and diversion services for youth involved with the juvenile justice system. Also, an on-site model classroom and learning lab will assist children with the transition to school environments and will support their academic achievement. And safe rooms and relaxation areas will be available for all ages, making the campus a trusted and valued resource for children and their families. To facilitate service coordination, staff from all child-serving systems, i.e., schools, juvenile probation, child protective services, Medicaid, sexual abuse services, will have on-site representatives.

As a result of the proposed project, in DY2, clinical operations will be manualized to enhance efficiency and accessibility to coordinated care. In DY3, the new and expanded campus will open. In DY4, the number of Bexar County children utilizing coordinating community behavioral health services will increase whereby in DY5, the volume of Bexar County children utilizing coordinating community behavioral health services will continue to increase.

Need for the project: Families of children with serious emotional disturbance, especially those involved with multiple systems (juvenile probation, schools, child welfare), and those with developmental disabilities and delays (including those where those disabilities or delays are attributed to their mothers use of substances while they were in utero) have difficulty accessing coordinated care. In the absence of a single site from which multi-faceted, multi-partner care is available, families often have to work with four or more entities and these entities often do not communicate with one another or efficiently share information.

Target population: Children with serious emotional disturbance. Based upon current service statistics, it is anticipated that 45% will be indigent and uninsured and 35% will be covered by Medicaid.

Category 1 or 2 expected patient benefits: The project seeks to increase utilization of community-behavioral healthcare. In DY4 an initial baseline of 460 will be served with a goal of 115 or 25% increase in access and utilization and in DY5 an increase of 230 or 50% of baseline will access and increase utilization. The proposed project will serve approximately 805 children by end of DY5.

Category 3 outcomes: IT-10.1 Quality of Life. Our goal for improvement in quality of life will
be determined in Year 4.  

**Project Description:**

The Center For Health Care Services (CHCS) seeks to establish a centralized, accessible campus from which systems or families can obtain care for children and adolescents (0 to 17 years old) with a serious emotional and/or behavioral problem or developmental delay. Services will include: comprehensive treatment planning, wraparound care, mental health interventions, coordination of care among all interested systems (schools, juvenile justice, child protective services), substance abuse counseling, group counseling for children, parents or caregivers and siblings, recreational therapy, ROPES course, connection to in-home services (occupational therapy, physical therapy, nutritional counseling, medication education, in-home nursing care), therapeutic foster care, and diversion services for youth involved with the juvenile justice system. Also, an on-site model classroom and learning lab will assist children with the transition to school environments and will support their academic achievement. And safe rooms and relaxation areas will be available for all ages, making the campus a trusted and valued resource for children and their families. To facilitate service coordination, staff from all child-serving systems, i.e., schools, juvenile probation, child protective services, Medicaid, sexual abuse services, will have on-site representatives. 

The Center for Health Care Services will fill an existing void in Bexar County by becoming the community’s primary resource regarding children’s mental health. Families will be able to visit the new campus to obtain information about their children’s mental health and available treatment options. Older youth will engage in scheduled and organized peer activities and community service projects, a new opportunity for most. Family Partners will be available to help parents and other caregivers identify resources designed to assist their children and strengthen their parenting skills. Parents will attend regularly scheduled training classes in becoming an effective advocate for their children. School staff and other community providers will be invited to specialized professional development opportunities regarding children’s mental health and the evidence-based practices that are available. Special populations also will be served. For example, children with developmental disabilities and a mental health diagnosis will be able to receive single-site occupational and physical therapy and continuity care after they age-out of the Early Childhood Intervention system. Also, children leaving the crisis and respite center or longer-term hospitalization will have the opportunity to continue treatment at the campus.

**Goals.** Establish a single location offering a continuum of care for children with behavioral health needs. Use the campus as a site for training staff from a variety of disciplines to increase the availability of pediatric specialists with behavioral health competencies.

**Challenges addressed by the project.** Families of children with serious emotional disturbance, especially those involved with multiple systems (juvenile probation, schools, child welfare), and those with developmental disabilities and delays (including those where disabilities or delays are attributed to their mothers use of substances while they were in utero) have difficulty accessing coordinated care. In the absence of a single site from which multi-faceted, multi-partner care is available, families often have to work with four or more entities and these entities often do not communicate with one another or efficiently share information.

**5-year expected outcomes for CHCS.** 1) Development of Children’s Behavioral Health Campus. 2) Expanded hours of operation for services. 3) Expanded continuum of services for children and adolescents and their caregivers. 4) Integration of Behavioral Health and Primary Health Care.

**5-year expected outcomes for persons served by the project.** 1) Improved quality of life and
functioning for children at school and at home. 2) Integration of primary care services into behavioral health setting so behavioral health services are an integral part of overall healthcare for children and adolescents. 3) Development of a continuum of care to include services and supports to help caregivers improve their abilities to successfully parent children and adolescents with behavioral health issues. 4) Establish comprehensive mental health services for children and adolescents including opportunities to connect to peers with similar experiences to promote improved family functioning and the ability to remain in their own home and community.

Relation to Regional Goals. Expanding resource availability to address the dearth of children’s mental health services is a key means of achieving the regional goal of “Improving the infrastructure for delivery of behavioral health services”. It also meets the CMS three part aim, as follows.

- The program fills an existing gap in care and **improves the existing behavioral health infrastructure** to better serve Medicaid and uninsured children in Bexar County.
- The program will meet children’s needs in an outpatient setting, which will reduce crisis and the need for hospital admissions and will **improve outcomes while containing cost growth**.

Starting Point/Baseline:
Children’s Mental Health currently is funded to serve 460 children per year.

Rationale:
The project option (1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas), process milestones (P-3 Develop administrative protocols and clinical guidelines for projects selected and P-6 Establish behavioral health services in new community-based settings in underserved areas) and improvement milestone (I-11 Increased utilization of community behavioral healthcare) were selected in correspondence to existing, unmet community needs for children’s outpatient mental health services.

Project Components: There are no project components for this option.

Unique community need identification numbers the project addresses:
- CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

More specifically, the proposed project will positively impact the following issues:
- Inadequate and fragmented continuum of care for children with behavioral health diagnoses.
- Inadequate access to care management and resource navigation

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

Related initiatives funded by U.S. Department of HHS. CHCS does not receive direct HHS funding for the Children's Outpatient Clinic. State mental health block grant funding is received via Texas Department of State Health Services but is insufficient to meet current needs. The proposed new initiative also will significantly enhance and expand and existing delivery system of the Children's Outpatient Clinic.
Related Category 3 Outcome Measure(s):

| OD-10 Quality of Life/Functional Status: |
| IT-10.1 Quality of Life. |

Reasons/rationale for selecting the outcome measures: This measure is indicative of consumer retention in care and enhanced stability, both of which are critical means of reducing unnecessary hospitalizations and the inappropriate use of emergency departments.

Relationship to other Projects:
There is one related project proposed for implementation in RHP 6: establishment of a children’s mental health emergency room in Bexar County. The children served in the emergency room could receive continuity care from CHCS from the proposed Children’s Mental Health campus.

Relationship to Other Performing Providers’ Projects in the RHP:
Clarity is proposing establishment of the Children’s Mental Health Emergency Room. CHCS will join Clarity in any University Health System-organized learning collaborative dedicated to sharing best practices and service solutions for children’s mental health.

Plan for Learning Collaborative:
CHCS will participate in any and all relevant learning collaborative organized by University Health System.

Project Valuation:
The value for this project is $1,758,764 for DY 2 and $7,752,406 for all years. By DY5, the proposed project will serve approximately 805 children per year. The expansion of Children’s Mental Health increases accessibility of behavioral health care for children. The availability of this new resource will ensure children are treated expediently, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the
health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of expanded Children's Outpatient Mental Health Services has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>137251808.3.5</th>
<th>3.IT-10.1</th>
<th>Quality of Life</th>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<td><strong>Milestone 1</strong></td>
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<td>P-3: Develop administrative protocols and clinical guidelines for projects selected)</td>
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<tr>
<td>Metric 1 P 3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines.</td>
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<tr>
<td>Goal: Improve service efficiency and accessibility. Data Source: Administrative protocols, clinical guidelines.</td>
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<td>Milestone 1 Estimated Incentive Payment: $1,758,764</td>
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<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
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<td><strong>Milestone 2</strong></td>
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<tr>
<td>P-6: Establish behavioral health services in new community-based settings in underserved areas</td>
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<tr>
<td>Metric 1 P-6.1: Number of new community-based settings where behavioral health services are delivered.</td>
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<tr>
<td>Baseline: Stand-alone services located at different sites attributing to access barriers for families with multiple service needs.</td>
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<tr>
<td>Goal: 1 new community based, co-located clinic integrating the continuum of services and access to care for families with multiple service needs.</td>
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<tr>
<td>Data Source: Number of patients served at new community-based</td>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<td><strong>Milestone 3</strong></td>
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<tr>
<td>I-11: Increased utilization of community behavioral healthcare</td>
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<tr>
<td>Metric 1 I-11.1: Percent utilization of community behavioral healthcare services.</td>
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<tr>
<td>Baseline: 460 children in service (DY3)</td>
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<td>Goal: 25% increase of 115 additional children served.</td>
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<td>Data Source: Claims and encounter data</td>
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<td>Milestone 3 Estimated Incentive Payment: $2,066,085</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 4</strong></td>
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<td>I-11: Increased utilization of community behavioral healthcare</td>
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<tr>
<td>Metric 1 I-11.1: Percent utilization of community behavioral healthcare services.</td>
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<tr>
<td>Goal: 50% increase from baseline or 230 additional children served a total of 805 served.</td>
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<td>Data Source: Claims and encounter data</td>
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<td>Milestone 4 Estimated Incentive Payment: $1,996,217</td>
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- Milestone 2 Estimated Incentive Payment: $1,931,340

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<tr>
<th>Year 2 Estimated Milestone Bundle Amount</th>
<th>Year 3 Estimated Milestone Bundle Amount</th>
<th>Year 4 Estimated Milestone Bundle Amount</th>
<th>Year 5 Estimated Milestone Bundle Amount</th>
</tr>
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<tbody>
<tr>
<td>$1,758,764</td>
<td>$1,931,340</td>
<td>$2,066,085</td>
<td>$1,996,217</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,752,406**
Identifying Project and Provider Information:
Title: 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Dual Diagnosis Clinic
Unique RHP ID#: 137251808.1.5 – PASS 2
Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services
Performing Provider TPI: 137251808

Project Summary:
Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.
Intervention(s): CHCS seeks to establish a comprehensive continuum of services, across the life span for individuals with co-occurring intellectual developmental disability (IDD), mental illness and substance use disorders. Services for individuals with co-occurring illnesses will include: medication management, comprehensive treatment planning, wraparound care, mental health interventions, skills development through in-home or clinic based services for occupational therapy, physical therapy, speech therapy, recreational therapy, and primary care access for routine medical services. Support services will be provided to caregivers by family support specialists. Telemedicine may be used to deliver medication management services to individuals with transportation challenges or whose disabilities prevent them from participating from clinic activities. To facilitate service coordination, wraparound care will be coordinated with staff from other systems also serving the IDD population, e.g., schools, Child and Adult Protective Services, Juvenile and Adult Probation, the local authority for IDD, and service providers. Finally, the addition of an on-site primary health care provider will give consumers access to integrated behavioral health and primary health care, increasing the possibility of treatment adherence. Continuity of care will be a primary focus for children with a dual diagnosis as they transition from Early Childhood Intervention Services. This clinic will be operated contiguous to the Children's Outpatient Clinic to achieve maximum efficiencies. However, evidence based practices demonstrate maximum benefit when these services are self-contained and adults served in this program do not interact with children served by the Outpatient Clinic.

Need for the project: Individuals with IDD experience a full range of psychiatric disorders similar to the general population; however, the occurrence of adjustment, anxiety, and impulse-control disorders or the need to complete a psychiatric consultation to rule them out, is higher. Individuals with dual diagnosis are frequently ostracized and often have limited support systems. Additionally, as they physically age out of childhood these individuals have difficulty adjusting to societal expectations of their physical age. Creating relationships with new providers and new care teams can be marked with anxiety, regression and acting out behaviors. Because of limited cognition, language skills, and social experiences as well as increased stress and anxiety related to overall functioning, it is critical that this population be cared for in a continuum of care with the same team and as little change as possible in the team of experienced professionals who can provide appropriate interventions, i.e., the right care in the right setting including transitional support services for aging caregivers. However, interest lists for Medicaid Waiver programs dedicated to these services are 2 to 10 years long.
Target population: Children, adolescents and adults with an existing determination of IDD or an IQ below 70, adults and children on the Autism Spectrum, and children and adults with an existing DSM mental health diagnosis and either Autism or an IDD. Based upon current service statistics, it is anticipated that 10% will be indigent and uninsured and 74% will be covered by Medicaid.

Category 1 or 2 expected patient benefits: The project seeks to increase utilization of community behavioral healthcare for this dual diagnosis population by increasing by 48 individuals (20%) in DY4 and 62 individuals 30% in DY5.

Category 3 outcomes: IT-10.1 Our goal, which will be quantified in DY4, is to improve quality of life for the children and families we serve.

Project Description:

The Center For Health Care Services (CHCS) seeks to establish a centralized, accessible clinic for children and adolescents (0 to 17 years old) with a co-occurring intellectual developmental disability (IDD) and mental illness and expand services to adults with a similarly co-occurring intellectual developmental disability (IDD) and mental health diagnosis. Services for individuals with co-occurring illnesses will include: medication management, comprehensive treatment planning, wraparound care, mental health interventions, skills development through in-home or clinic based services for occupational therapy, physical therapy, speech therapy, recreational therapy, and primary care access for routine medical services. Support services will be provided to caregivers by family support specialists. Telemedicine may be used to deliver medication management services to individuals with transportation challenges. To facilitate service coordination, wraparound services will be coordinated with staff from other systems also serving the IDD population, e.g., schools, Child and Adult Protective Services, Juvenile and Adult Probation, the local authority for IDD, and service providers. Finally, the addition of an on-site primary health care provider will give consumers access to integrated behavioral health and primary health care, increasing treatment compliance.

The population to be served will include children and adults with an existing determination of intellectual developmental disability (IDD) or an IQ below 70, adults and children on the Autism Spectrum, and children and adults with an existing DSM mental health diagnosis and either Autism or an intellectual developmental disability (IDD). Continuity of care will be a primary focus for children with a dual diagnosis who are transitioning out of Early Childhood Intervention (ECI) Services.

Individuals with IDD experience a full range of psychiatric disorders similar to the general population; however, the occurrence of adjustment, anxiety, and impulse-control disorders or the need to complete a psychiatric consultation to rule them out, is higher. These individuals reside in a range of settings, e.g., residential facilities, group homes, supported living programs, and with family or friends, but public policy continues to promote the least restrictive setting with appropriate medical and mental health services. Individuals with dual diagnosis are frequently ostracized and often have limited support systems. As such, indicators of a mental health problem may be ignored or mistaken for “acting out”. Because of limited cognition, language skills, and social experiences as well as increased stress and anxiety related to overall functioning, it is critical that this population be evaluated by experienced professionals who can provide appropriate interventions, i.e., the right care in the right setting.

Goals. Increase access for children and adults with a dual diagnosis of mental illness and
intellectual developmental disability to a continuum of co-located services, including psychiatric, medication evaluation and management, and primary health care.

**Challenges addressed by the project.** Individuals with the dual diagnosis of mental illness and IDD typically have resided in institutional settings. Today, a growing number reside in the community, often with family, and rely on community resources for treatment; however, interest lists for Medicaid Waiver programs dedicated to these services are 2 to 10 years long. Effective mental health treatment for this population requires two key components: 1) utilization of an interdisciplinary team aware of the complexity of mental health issues among individuals with IDD, including how symptoms can be masked by the behaviors intrinsic to the intellectual disability, and 2) routine integration of caregiver feedback, insights from those who know and understand the consumer the best and can accurately communicate symptoms and daily functioning.

**5-year expected outcomes for CHCS.** 1) Expanded provision of dual diagnosis services. 2) Expanded hours of operation. 3) Effective continuum of services for dually diagnosed children, adolescents, adults, and their caregivers. 4) Integrated behavioral health and primary health care for individuals with dual diagnosis.

**5-year expected outcomes for persons served by the project.** 1) Increased access to services to promote improved functioning and the ability to remain in-home and community. 2) Improved physical and behavioral health as a result of integrated, single site primary care and behavioral health services. 3) Development of a continuum of care that includes essential services and supports from a single site. 4) Improved quality of life and functioning.

**Relation to Regional Goals.** Expanding resource availability to address the unmet needs of individuals with dual diagnosis is a key means of achieving the regional goal of “Improving the infrastructure for delivery of behavioral health services”. It also meets the CMS three part aim, as follows.

- The program fills an existing gap in care and **improves the existing behavioral health infrastructure** to better serve Medicaid and uninsured children and adults in Bexar County.
- The program will meet the needs of dually diagnosed children and adults in an outpatient setting, which will reduce the need for hospital admissions and will **improve outcomes while containing cost growth**.

**Starting Point/Baseline:**

CHCS currently provides psychiatric services to approximately 40 dually diagnosed clients per month.

**Rationale:**

The project option (1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas), process milestones (P-3 Develop administrative protocols and clinical guidelines for projects selected and P-6 Establish behavioral health services in new community-based settings in underserved areas) and improvement milestone (I-11Milestone: Increased utilization of community behavioral healthcare) were selected in correspondence to existing, unmet community needs for services to individuals with dual diagnosis of mental illness and intellectual developmental disability.

The proposed project addresses the following community need identification numbers:
• **CN.4** – Shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

More specifically, the proposed project will positively impact:

- Inadequate and fragmented continuum of care for children with behavioral health diagnoses.
- Need for integrated behavioral health and primary care services.
- Inadequate resources for special needs populations, including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders.
- Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments.

How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: Expansion of an existing initiative.

Related initiatives funded by U.S. Department of HHS. CHCS does not receive direct HHS funding for this program.

**Related Category 3 Outcome Measure(s):**

<table>
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<tr>
<th>OD-10 Quality of Life/Functional Status</th>
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<tr>
<td>IT-10.1 Quality of life</td>
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**Reasons/rationale for selecting the outcome measures:** These measures are indicative of consumer retention in care and enhanced stability.

**Relationship to other Projects:**

There is one children’s project proposed for implementation in RHP 6 that is related: establishment of a children’s mental health emergency room in Bexar County. The children served in the emergency room could receive continuity care from CHCS through the proposed Dual Diagnosis Program. CHCS’s Adult Outpatient Services program also will be a referral source for dually diagnosed adults in their caseload.

**Relationship to Other Performing Providers’ Projects in the RHP:**

Clarity is proposing establishment of the Children’s Mental Health Emergency Room. CHCS will join Clarity in any University Health System-organized learning collaborative dedicated to sharing best practices and service solutions for children’s mental health.

**Plan for Learning Collaborative:**

CHCS will participate in any and all relevant learning collaboratives organized by University Health System.
### Project Valuation:

The value for this project is $1,653,898 for DY 2 and $7,287,006 for all years. By DY5, 62 dually diagnosed patients will be receiving highly specialized project services. The proposed expansion of a Dual Diagnosis clinic for children and adults with co-occurring mental illness and intellectual developmental disability will increase accessibility of behavioral health care and will integrate primary care for this unique, underserved population. The availability of this expanded resource will ensure dually diagnosed children and adults are treated expeditiously, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of expanded services for dually diagnosed individuals, i.e., children, adolescents and adults with an existing determination of IDD or an IQ below 70, adults and children on the Autism Spectrum, and children and adults with an existing DSM mental health diagnosis and either Autism or an IDD, has the potential to increase QALY among those it serves.

This valuation used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program’s value is based on a monetary value of $50,000 per QALY gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-
A description of the method used, titled ‘Valuing Transformation Projects,’ has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.
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<tr>
<th>Category</th>
<th>Outcome Measure(s)</th>
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<td>Year 2</td>
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<td>Year 3</td>
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<td>Year 4</td>
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<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
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### Milestone 1

**P-3:** Develop administrative protocols and clinical guidelines.

**Goal:** Protocols developed.

**Data Source:** Administrative protocols, clinical guidelines.

**Milestone 1 Estimated Incentive Payment:** $1,653,898

#### Year 2

**Milestone 2**

**P-6:** Establish behavioral health services in new community-based settings in underserved areas

**Metric 1 P.6.1:** Number of new community-based settings where behavioral health services are delivered.

**Goal:** 1 new community-based clinic with specialized services for dually diagnosed individuals across their life span, with co-located integrated services

**Data Source:** Number of co-located clinics and patients served at new site.

**Milestone 2 Estimated Incentive Payment:** $1,811,473

**Year 2 Estimated Milestone Bundle Amount:** $1,653,898

### Milestone 3

**I-11:** Milestone: Increased utilization of community behavioral healthcare

**Metric 1 I-11.1:** % of increased utilization of community behavioral healthcare.

**Goal:** 20% increase; 48 patients served.

**Data Source:** Clinical records.

**Milestone 3 Estimated Incentive Payment:** $1,944,800

**Year 3 Estimated Milestone Bundle Amount:** $1,811,473

### Milestone 4

**I-11:** Milestone: Increased utilization of community behavioral healthcare

**Metric 1 I-11.1:** % of increased utilization of community behavioral healthcare.

**Goal:** 30% increase; 62 patients served.

**Data Source:** Clinical records.

**Milestone 4 Estimated Incentive Payment:** $1,876,835

**Year 4 Estimated Milestone Bundle Amount:** $1,944,800

### Year 5

**Milestone 4 Estimated Milestone Bundle Amount:** $1,876,835

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,287,006
Identifying Project and Provider Information:

Title: 1.8.9 – The implementation or expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise underserved children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.

Unique RHP ID#: 091308902.1.1 (PASS 1)
Performing Provider: San Antonio Metropolitan Health District
Performing Provider TPI: 082426001

Project Summary:

Provider Description: The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals.

Intervention(s): The project will improve access to preventive dental services (dental sealants and fluoride varnish applications) by providing preventive oral health services in non-traditional settings to include early childhood education settings and economically disadvantaged public schools. The project also supports early identification of children with unmet dental needs, and reinforces the importance of linking families to a “main dental home” in the community where they may receive comprehensive oral health services. These services will be available to children not enrolled in the Head Start program that already receive federal funding for oral health services provided by Metro Health.

Need for the project: Development of an alternative means to deliver preventive care in alternative settings has become increasingly important with the transition of Texas Medicaid from a fee-for-service model to a managed care model. Under the new plan, all dental services must be provided through a “main dental home” or through specialist referral coordinated through the main dental home. This model can be enhanced through the use of complementary community-based preventive services in non-traditional settings which can help reach children that are not currently being served. The strongest predictor of future dental decay is a history of previous decay (caries experience).

Using a population-based approach to risk assessment, the rate of caries experience (62.2% in elementary school-aged participants), combined with other risk factors such as low socioeconomic status of target sites and schools (all 70% or greater economically disadvantaged) and race/ethnicity of target population must all be considered in development of a treatment/services plan for target schools.

These community-based interventions do not conflict with the “main dental home” model, but, rather provide an opportunity to identify Medicaid beneficiaries that have not accessed dental services covered under the plan and facilitate referral to their designated dental home. A review
of the data collected by Metro Health for 6,344 children enrolled in the City of San Antonio’s Head Start Program revealed that 95% of enrolled children are also enrolled in the Texas Medicaid Program and have a “main dental home”. However, upon examination, Metro Health dentists identified one in four children that had obvious clinical signs of untreated decay. Similarly, preliminary data collected for elementary school-aged children in Bexar county suggests that approximately 48% have untreated dental disease.

Target population: The project aims to improve access to preventive dental care for economically disadvantaged children attending early education pre-kindergarten programs (other than Head Start) and elementary schools in Bexar County. School campuses with an enrollment of at least 70% economically disadvantaged children will be eligible for participation. Children enrolled in Texas Medicaid and CHIP as well as those who are not eligible for public insurance will be served through the project. In this way, a greater number of children with needs will be identified sooner and can be linked to either a “dental home” or provider that can take care of these needs in a more timely fashion, lessening the likelihood of further breakdown of the dentition or loss of teeth. Referrals for follow up care will be coordinated with the child’s main dental home, if applicable, or another community provider. The focus is on preventive services for children with documented limited access to a dental home and/or a long delay since their last evaluation for health services.

Category 1 or 2 expected patient benefits: Project goals include volume incremental increases in DY3, DY4 and DY5; which will be measured by the number of unduplicated patients that access one or more oral health services through the project during the measurement period. Ultimately, the expected outcome is to expand the reach of Metro Health’s existing safety net dental programs for Head Start children to serve additional pre-school and elementary school-aged children which would result in improved access to preventive dental care for approximately 32,500 children in Bexar County over the course of the waiver. The table below outlines the age appropriate services for each group of children and the expected volume of services for DY3-5:

<table>
<thead>
<tr>
<th>Unduplicated Patients</th>
<th>2013-2014 School Year</th>
<th>2014-2015 School Year</th>
<th>2015-2016 School Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Kindergarten</td>
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<tr>
<td>Kindergarten</td>
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<tr>
<td>2nd Grade</td>
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<td>3rd Grade</td>
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<tr>
<td>ANNUAL TOTALS:</td>
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<tr>
<td></td>
<td>Children Served: 8,126 Fluoride Varnish Applications: 9,585 Dental Sealants: 7,185</td>
<td>Children Served: 10,834 Fluoride Varnish Applications: 12,779 Dental Sealants: 9,583</td>
<td>Children Served: 13,540 Fluoride Varnish Applications: 15,971 Dental Sealants: 11,975</td>
</tr>
</tbody>
</table>
Category 3 outcomes: OD- 7 Oral Health

These selected outcome measures demonstrate both the provision of needed preventive oral health services for children served through the project (IT-7.1 and IT-7.3) as well as ultimate reductions in adverse oral health outcomes (IT-7.6) for the populations served.

- IT-7.1 Dental Sealants – % of children age 6-9 with a dental sealant on a permanent first molar tooth
- IT-7.3 Early Childhood Caries – Fluoride varnish applications
- IT-7.6 Urgent Dental Care Needs in Children – % of children with urgent dental care needs

Project Description:

Project Overview

Currently, the City operates community-based prevention programs that provide access to early diagnosis, fluoride varnish and dental sealants for more than 15,000 children at high risk for dental decay. These programs have included services for nearly 7,000 Head Start children (federally funded) and over 8,000 students through a school-based sealant grant (federal pass through) which will end in August 2013. These programs have been developed and implemented using the most current evidence-based strategies to prevent dental disease and reduce oral health disparities. Programs provide case management support for children identified with urgent dental conditions including those who are uninsured or underinsured for required treatment. Additionally, Metro Health provides oral health education, training and technical assistance for Head Start and Early Head Start faculty and staff, and serves as a resources for school nurses in local districts served by the programs. As a Region 6 performing provider, Metro Health will expand the reach of early childhood services beyond the Head Start population and will be able to reinitiate school based sealant services for elementary children to serve children with unmet dental needs.

Dental caries is the most common chronic disease of childhood. Children living in poverty are disproportionately affected, and experience nearly 12 times as many restricted-activity days compared to their higher income counterparts. Nationwide, an estimated 51 million school hours are lost each year due to dental-related illness. Poor oral health has been related to compromised nutritional intake, decreased school attendance and performance, poor social relationships and reduced self-esteem.

School based sealant programs and fluoride varnish preventive treatments are among the strongest evidence-based interventions for prevention of dental caries and adverse oral health outcomes for children. These interventions, in a context of preventive oral health assessments and follow up treatments will be expanded in local schools and non-traditional settings to prevent future adverse oral health outcomes for Medicaid and other underserved populations. The use of non-traditional settings is critical to reaching underserved children that are not being served in a main dental home.

Additionally this project will seek to develop and refine progress in serving the oral health needs of children through participation in a variety of Continuous Quality Improvement activities including participation in a regional learning collaborative, partnership with the UTHSCSA on program improvement analysis and activities and work with other Metro Health projects on CQI
as outlined in milestones 2, 4, 6 and 8.

**Goals and Relationship to Regional Goals**

**Project Goals:**
1. Providing preventive oral health services in non-traditional settings such as early childhood centers to non-Head Start children and to economically disadvantaged public schools.
3. Linking children to comprehensive oral health services through private, public and other community partners within the context of the main dental home model.

This project meets the following regional goals:
This project directly addresses the RHP 6 need to expand access for dental services within the region (CN.3).

**Project Goals and 5 Year Expected Outcome for Performing Provider and Patients:**
Project goals include volume incremental increases in DY3, DY4 and DY5; which will be measured by the number of unduplicated patients that access one or more oral health service through the project during the measurement period. Ultimately, the expected outcome is to expand the reach of Metro Health’s existing safety net dental programs to serve additional preschool and elementary school-aged children which would result in improved access to dental care for approximately 32,500 children in Bexar County over the course of the waiver.

These community-based interventions do not conflict with the “main dental home” model, but, rather provide an opportunity to identify Medicaid beneficiaries that have not accessed dental services covered under the plan and facilitate referral to their designated dental home. A review of the data collected by Metro Health for 6,344 children enrolled in the City of San Antonio’s Head Start Program revealed that 95% of enrolled children are also enrolled in the Texas Medicaid Program and have a “main dental home”. However, upon examination, Metro Health dentists identified one in four children that had obvious clinical signs of untreated decay. Similarly, preliminary data collected for elementary school-aged children in Bexar county suggests that approximately 48% have untreated dental disease.

Project metrics will include collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators will be captured directly on site on elementary school campuses for children enrolled in Pre-K, Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC’s S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

**Challenges/Opportunities:**
According to the Centers for Medicare and Medicaid Services 2010 Annual EPSDT Participation Report (CMS-416), 1,429,066 children (47.3%) enrolled in Texas Medicaid did not receive a single preventive service during a 12 month period. Provision of preventive dental services in
non-traditional settings, will remove barriers to care for children living in poverty and improve oral health outcomes for children at high risk for disease. Specific programs for consideration target provision age-appropriate preventive interventions including fluoride varnish and dental sealants in outreach locations. Development of an alternative means to deliver preventive care in alternative settings has become increasingly important with the transition of Texas Medicaid from a fee-for-service model to a managed care model. Under the new plan, all dental services must be provided through a “main dental home” or through specialist referral coordinated through the main dental home.

The goal of this program is to address these challenges by providing a complementary service to the main dental home. The Metro Health dental program has consistently identified children that are covered by Texas Medicaid and CHIP with untreated dental decay and helped them obtain access to a main dental home through a variety of special projects and grant funded programs. 

**Starting Point/Baseline:**

**School-Based Oral Health Prevention Program-Children (Children ages 6-9)**

Metro Health provides diagnostic and preventive services on the campuses of local elementary schools with the highest concentration of children living in poverty. During the 2011-2012 academic school year, the City’s previously grant funded school-based sealant program reached 69 elementary school campuses in 5 school districts. A total of 8,961 children received one or more diagnostic and/or preventive service during the previous program period, with 1,760 second grade students received dental sealants. A total of 8,961 fluoride varnish applications and 5,291 dental sealants were applied for participating children. However with the loss of these grant funds the program will not be able to provide school-based exams and sealants without 1115 funding. The project table is set at zero for DY3.

**Early Childhood Oral Health Program (Children ages birth through 5)**

Metro Health provides diagnostic and preventive services on site in Head Start Centers throughout Bexar County for approximately 7,000 children ages 3-5 enrolled in the local program. During the 2011-2012 academic school year, Metro Health served 6,897 children ages 3-5 years enrolled in Head Start. In addition to a limited oral examination performed by a dentist, program staff administered 12,135 applications of fluoride varnish. These Head Start services are supported by federal funds and will not be counted as part of this proposed project. The baseline for non-Head start services is set at zero and this project will seek to expand services to children not funded by Head Start, many of which are co-located in the same classrooms and schools as children that do receive Head Start services.

**Rationale:**

Community water fluoridation and school-based sealant programs are the foundation of dental caries prevention of and reduction of oral health disparities. Community assessment data collected from the City’s oral health outreach programs serve as evidence of the need for new and innovative solutions to eliminate barriers to accessing preventive dental care such as fluoride varnish applications and dental sealants. The strongest predictor of future dental decay is a history of previous decay (caries experience). Using a population-based approach to risk assessment, the rate of caries experience (62.2% in elementary school-aged participants), combined with other risk factors such as low socioeconomic status of target sites and schools (all 70% or greater economically disadvantaged) and race/ethnicity of target population must all be
Unique community need identification number the project addresses:
This project directly addresses the RHP 6 need to expand access for dental services within the region (CN.3).

Provide services to economically disadvantaged elementary schools through the Metro Health School-Based Oral Health Prevention Program
Rationale/Evidence:
- School-based dental sealant programs have been identified by the CDC as a preventive measure that has strong evidence demonstrating effectiveness in the prevention of dental caries and allow for low-income high risk children to receive dental sealants that otherwise may not have the opportunity to receive them.
- Measuring increase in special high risk populations accessing dental services reflects the goals of addressing health disparities in access to dental care.

Expand the reach of Metro Health’s current oral health prevention for economically disadvantaged pre-kindergarten children (ages birth through 5) to children not enrolled in Head Start
Rationale/Evidence:
- Identified by the CDC as a preventive measure that has strong evidence demonstrating effectiveness in the prevention of dental caries and allow for low-income high risk children to receive fluoride varnish applications that otherwise may not have the opportunity to receive them.
- Measuring increase in special high risk populations accessing dental services reflects the goals of addressing disparities in access to dental care
- Children who have regular access to a dental provider are more likely to have received dental services such as fluoride varnish applications.
- Children are less likely to suffer from more severe, urgent oral health problems with adequate and regular access to dental care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project would allow for a significant expansion of the number of children served through the Metro Health preventive oral health program. Funding for this project would be utilized to reach new school and community locations not previously served by the Metro Health program and to reinstate services in elementary schools which have lost funding for school based oral health services.

Related Category 3 Outcome Measure(s):
OD-7 Oral Health
- IT-7.1 Dental Sealants – % of children age 6-9 with a dental sealant on a permanent first molar tooth
- IT-7.3 Early Childhood Caries – Fluoride varnish applications
### IT-7.6 Urgent Dental Care Needs in Children – % of children with urgent dental care needs

#### Reasons/rationale for selecting the outcome measures:
These selected outcome measures demonstrate both the provision of needed preventive oral health services for children served through the project (IT-7.1 and IT-7.3) as well as ultimate reductions in adverse oral health outcomes (IT-7.6) for the populations served. These measures closely align with the RHP 6 goals in terms of both expanded oral health services and reductions in adverse oral health outcomes.

#### Relationship to other Projects:
Metro Health and the UT Health Science Center Dental School have a long-standing community partnership. In addition to collaborative efforts in support of community water fluoridation, the local health department and dental school work closely to ensure access to quality dental care is available in Bexar County and that future oral health training programs include relevant community health experiences for students.

In 2010, the UT Health Science Center Dental School was granted a 3 year award through the Health Resources and Services Administration that included a sub contractual agreement with Metro Health to develop and implement a model school-based oral health prevention program.

In addition to the Texas Oral Health Workforce Grant, contractual agreements between these two entities are in place that allows Metro Health to provide direct reimbursement to the University for provision of comprehensive dental care for income-eligible children referred for comprehensive care. The UT Health Science Center clinics serve as the primary referral source for children who are uninsured or underinsured for the care needed to be restored to health. Specifically, the University’s Ricardo Salinas Clinic provides approximately 5,000 patient visits for low income children on an annual basis, many of which are not eligible for Medicaid or CHIP.

The UT Health Science Center Dental School’s community-based clinical activities at the Ricardo Salinas Dental Clinic and the San Antonio Christian Dental Clinic at the Haven for Hope campus serve as key components of the local dental safety net. Both pre-doctoral students and pediatric dentistry residents gain hands-on experience working with at-risk populations by providing care in these sites. In addition to the training experiences gained through the University’s traditional clinic rotations, community health rotations have also been established for students to work with Metro Health to provide fluoride varnish and dental sealants in non-traditional settings.

#### Relationship to Other Performing Providers’ Projects in the RHP:
Relative to the UT Health Science Center Dental School DSRIP project proposals, preliminary discussions have taken place regarding linkage of community-based patient encounters with certified electronic health records. The University’s proposal also seeks to establish emergency dental clinics, which could serve as a vital referral source for the residents that contact Metro Health for assistance in locating emergency dental services.
## Plan for Learning Collaborative:

Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 2, 4, 6 and 8 beginning in DY2. Additionally, Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.

## Project Valuation:

Numerous studies have documented the value of preventive oral health services, specifically school-based sealants and fluoride varnish applicants in reducing subsequent dental visits, restorative care and emergency visits. Overall children receiving preventive services incur lower dental costs.

Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following factors in assigning a value to this preventive oral health project: achievement of waiver goals, community need, project scope and the level of project investment.

- This project was ranked high on achievement of waiver goals given the strong research and high potential for reduction of oral health costs for Medicaid and other underserved populations of children in Bexar County. This project will expand access to oral health services, emphasize effective evidence-based preventive services, provide opportunities for coordinated care between community based preventive services and follow up care through the main dental home model, and reduce costs.
- This project was ranked moderately in regards to addressing a community need. While this project is consistent with the RHP need to expand dental services other community health needs have been more prominent in public surveys and community planning efforts.
- This project was ranked low on project scope in that services will be focused on children only in specific community settings which is a more narrow target population than other Metro Health proposed projects.
- This project was ranked moderately in regards to program investment in that the selected project requires individual screening and case management of patients rather than population-based approaches which will be more resource intensive for both project implementation and evaluation.
<table>
<thead>
<tr>
<th><strong>091308902.1.1</strong></th>
<th><strong>1.8.9</strong></th>
<th><strong>N/A</strong></th>
<th><strong>EXPANSION OF SCHOOL-BASED SEALANT AND FLUORIDE VARNISH PROGRAMS</strong></th>
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<tr>
<td><strong>PASS 1</strong></td>
<td><strong>N/A</strong></td>
<td><strong>N/A</strong></td>
<td><strong>Dental Sealants</strong></td>
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<td><strong>San Antonio Metropolitan Health District</strong></td>
<td><strong>TPI - 082426001</strong></td>
<td><strong>Early Childhood Caries-Fluoride Varnish Applications</strong></td>
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<td><strong>Related Category 3</strong></td>
<td><strong>091308902.3.1</strong></td>
<td><strong>IT-7.1</strong></td>
<td><strong>Urgent Dental Care Needs in Children</strong></td>
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<td><strong>Outcome</strong></td>
<td><strong>091308902.3.2</strong></td>
<td><strong>IT-7.3</strong></td>
<td><strong>Data Source: MOUs with schools, school sealant program schedule</strong></td>
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<td><strong>Measure(s):</strong></td>
<td><strong>091308902.3.3</strong></td>
<td><strong>IT-7.6</strong></td>
<td><strong>Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services</strong></td>
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<table>
<thead>
<tr>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
<th><strong>Year 4</strong></th>
<th><strong>Year 5</strong></th>
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<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
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<tr>
<td><strong>[P-6]: Implement/expand alternative dental care delivery systems to underserved populations</strong></td>
<td><strong>[I-14]: Increase number of special population members that access dental services</strong></td>
<td><strong>[I-14]: Increase number of special population members that access dental services</strong></td>
<td><strong>[I-14]: Increase number of special population members that access dental services</strong></td>
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<td><strong>Metric 1 [P-6.3]: Implement or expand school-based sealant program</strong></td>
<td><strong>Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services</strong></td>
<td><strong>Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services</strong></td>
<td><strong>Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services</strong></td>
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<tr>
<td><strong>Goal: Document the expansion of a program plan and schedule of schools for the 2013-2014 academic year.</strong></td>
<td><strong>Baseline: 0 non Head Start children served</strong></td>
<td><strong>Baseline: 0 non Head Start children served</strong></td>
<td><strong>Baseline: 0 non Head Start children served</strong></td>
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<tr>
<td><strong>Data Source: MOUs with schools, school sealant program schedule</strong></td>
<td><strong>Goal: 8,126 children in PreK, Kindergarten, 2nd and 3rd grades</strong></td>
<td><strong>Goal: 10,834 children in PreK, Kindergarten, 2nd and 3rd grades</strong></td>
<td><strong>Goal: 13,540 children in PreK, Kindergarten, 2nd and 3rd grades</strong></td>
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<td><strong>Metric 2 [P-6.4]: Implement program to increase dental services to improve maternal and early childhood oral health</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</strong></td>
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<tr>
<td><strong>Goal: Document the expansion of a community based oral health program for pre-school children not enrolled in Head Start.</strong></td>
<td><strong>Baseline: 0 Goal: 7,185 sealants for children in 2nd and 3rd grades</strong></td>
<td><strong>Baseline: 0 Goal: 9,583 sealants for children in 2nd and 3rd grades</strong></td>
<td><strong>Baseline: 0 Goal: 11,975 sealants for children in 2nd and 3rd grades</strong></td>
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<td><strong>Data Source: MOUs with schools and community based organizations, pre-school oral health program schedule</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other</strong></td>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other</strong></td>
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<tr>
<td><strong>Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</strong></td>
<td><strong>Baseline: 0</strong></td>
<td><strong>Baseline: 0</strong></td>
<td><strong>Baseline: 0</strong></td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $987,355.50</td>
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</table>
| **Milestone 2**  
[P-8]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| **Metric 1 [P-8.1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-8.2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Goal: Share challenges and solutions in collaborative meetings/calls.  
Data Source: Catalogue of challenges, solutions, tests, and documentation of dental services |
| Milestone 3 Estimated Incentive Payment: $1,030,026.00 |
| **Milestone 5 Estimated Incentive Payment: $1,040,672.50** |
| **Milestone 4**  
[P-8]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| **Metric 1 [P-8.1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-8.2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Goal: Share challenges and solutions in collaborative meetings/calls. |
| Milestone 6 Estimated Incentive Payment: $1,040,672.50 |
| **Milestone 7 Estimated Incentive Payment: $1,064,626.50** |
| **Milestone 8**  
[P-8]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| **Metric 1 [P-8.1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-8.2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Goal: Share challenges and solutions in collaborative meetings/calls.  
Data Source: Catalogue of challenges, solutions, tests, and documentation of dental services  
ChildPlus or other data management system, other documentation of dental services |
progress shared by the participating provider during each bi-weekly interaction.

Milestone 2 Estimated Incentive Payment: $987,355.50

Milestone 4 Estimated Incentive Payment: $1,030,026.00

Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 6 Estimated Incentive Payment: $1,040,672.50

Milestone 8 Estimated Incentive Payment: $1,064,626.50

Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Year 2 Estimated Milestone Bundle Amount: $1,974,711

Year 3 Estimated Milestone Bundle Amount: $2,060,052

Year 4 Estimated Milestone Bundle Amount: $2,081,345

Year 5 Estimated Milestone Bundle Amount: $2,129,253

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,245,361
Identifying Project and Provider Information:

Title: 2.8.1 Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency
Unique RHP ID#: 159156201.2.1 – PASS 1
Performing Provider: VHS San Antonio Partners, LLC d/b/a Baptist Health System
Performing Provider TPI: 159156201

Project Summary:

Provider Description: Baptist Health System includes five acute- (Baptist Medical Center (623 beds), Mission Trail Baptist Hospital (110 beds), North Central Baptist Hospital (280 beds), Northeast Baptist Hospital (379 beds), and St. Luke’s Baptist Hospital (282 beds)) which offer 1,674 licensed beds. In 2011, Baptist Health System was recognized by U.S. News and World Report for earning more, high performing specialty rankings (5) than any other health system in the San Antonio metropolitan area. All five hospitals have earned Accredited Chest Pain Center designation, as well as Primary Stroke Center Certification. Medicare has designated each as Texas’ only Medicare Value Based Care Centers. The system also includes Baptist Regional Children’s Center, Baptist Breast Center, HealthLink wellness and fitness center, Baptist M&S Imaging Centers, community health and wellness programs, ambulatory services, rehabilitation services, air medical transport, School of Health Professions, and other health-related services and affiliations. It is part of the Nashville, Tennessee-based Vanguard Health Systems.

Intervention(s): Using the enhanced Performance Improvement capacity created with Project 1.10, Baptist will apply these tools to identify clinical care areas and processes to conform to current best practices and reduce variation in treatment plans and health outcomes. Baptist will drive process improvement in at least the following specific clinical areas:
1. Bowel Surgery- Utilization of TPN and ICU
2. Congestive Heart Failure LOS and utilization of pharmaceuticals, imaging and lab diagnostics
3. Variation in diagnostics and treatment patterns among ED practitioners for #1 presenting complaint of abdominal pain

Need for the project: The five year goal is to improve patient care and outcomes, reduce cost and variation in processes while improving clinical care, patient outcomes and improving the total patient experience. We will target specific clinical processes already identified and continue a similar process to improve additional clinical areas which will improve patient care and experience. Healthcare quality in Texas overall is low, there are critical shortages in providers and access, high indigent and Medicaid populations, widespread chronic disease in diabetes and cardiac illness, so focusing on targeted clinical conditions with high volume and/or wide variation, narrows the gap in all of these areas of need. Improving the care and quality also improves access to restricted resources for other patients. These goals meet Triple Aim, the RHP 6 Regional Goals and our RHP Community Needs.

We have already evaluated the three clinical conditions noted above and found wide variation in significant volumes of patients.

Target population:
The current Baptist Health System annual volumes for these three clinical initiatives:
Bowel Surgery = 610 surgeries
CHF = 1309 admissions
Abdominal pain upon presentation to ED = 16,245 patients or 7.3% of all Baptist ED visit
Surgical Operations improvements will have widespread impact as BHS performs almost 34,000 annual surgeries. Over 26% of BHS’ Inpatient population is Medicaid or Uninsured indigent and another large % have Medicaid supplemental to Medicare. Over 43% of BHS’ Outpatient population is Medicaid or Uninsured indigent and another large % have Medicaid supplemental to Medicare. The impact of these quality and cost improvements through standardization and reduction in variation will greatly benefit this patient population.

Category 1 or 2 expected patient benefits:
The expected benefit of this project to patients is improved quality of services. Specifically, BHS expects patients having bowel surgery to have reduced length of stays, reduced usage of TPN, and reduced ICU utilization. BHS also expects patients with chronic heart failure to have reduced length of stays and reduction in variation in usage of pharmaceuticals, imaging and lab diagnostics during treatment of CHF. For Surgical Operations Improvements the focus with quantifiable impact will be reduction of surgical site infections, reduction in supply cost per case through standardization and improved first case on time starts. By DY 5, the goal is to have 20% improvement in measure outcomes for bowel surgery and CHF identified. However, because of the nature of this project, BHS cannot identify the actual reductions in length of stay until DY 2, when the process improvement tools have been developed.

Category 3 outcomes:
Congestive Heart Failure 30 day readmission rate
Acute Myocardial Infarction (AMI) 30 day readmission rate

Project Description:
Building on the infrastructure of performance improvement that will be established under project 1.10, BHS will implement lean and six sigma performance improvement methodology to improve the safety, quality, patient experience, and efficiency in targeted service areas. Specifically, the infrastructure built under 1.10 will give BHS the tools to identify service areas that are in need of performance improvement and an evidence-based methodology to address those clinical deficiencies.

The goal of this project is to apply these tools to identify clinical care areas and processes to conform to current best practices and reduce variation in treatment plans and health outcomes. The tools used under the lean and six sigma methodology include, FMEA, value stream mapping, process mapping, identification and elimination of waste and non-value added processes. Using these tools, BHS will drive process improvement in at least the following specific clinical areas:

1. Bowel Surgery—we have identified wide variation in the use of TPN (Total Parenteral Feeding) post bowel surgery. Using the Aspen Association for Parenteral Feedings best practice guidelines we will implement best practices for TPN usage post bowel surgery. This will reduce variation, improve patient quality and reduce costs. We have also found wide variation in ICU utilization post bowel surgery. Using APACHE criteria we will work to ensure ICU utilization is per evidence based medicine.
2. Similarly we are in the analysis stage for CHF LOS variances as well as wide variation in the utilization of pharmaceuticals, imaging and lab diagnostics and identify and report on processes for improvement in quality and efficiency/cost.

3. Our third area under analysis for improvement is the variation in diagnostics and treatment patterns among ED providers for patients who present to the ED with a chief complaint of abdominal pain—which is BHS’ largest volume presenting condition in the ED.

Other areas scheduled for in depth analysis include variation in C Section and Vaginal delivery hospital care.

**Challenges** center on changing physician practice patterns. BHS will use the PI tools, include physicians and other practitioners, access Evidence Based Medicine (EBM) studies and protocols or maps and address the challenges with targeted data and analysis that will lead the involved physicians to common solutions reducing variation and improving care.

The **five year goal** is to improve patient care and outcomes, reduce cost and variation in processes while improving clinical care, patient outcomes and improving the total patient experience. We will target specific clinical processes already identified and continue a similar process to improve additional clinical areas which will improve patient care and experience.

This **project meets the RHP Regional Goals**:  
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways  
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties  
- Further develop and maintain a coordinated care delivery system  
- Improve outcomes while containing cost growth

This project **meets the following RHP identified Community needs**:  
CN.1 Texas ranks last in the nation on health care quality

BHS Operational improvement Office will use P-3 Quality Improvement Milestone to further enhance the PI impact on improving care, quality and cost for our patients.

**Starting Point/Baseline:**

BHS has identified three clinical focus areas to target for reducing variation in process and/or clinical variation as compared to DY1 outcomes: bowel procedures, congestive heart failure, and top volume ER diagnosis. We will measure progress on these projects over DY3-5 and will identify additional clinical areas to target in DY3.

**Rationale:**

Variation exists within health care practices across the RHP 6 area and even within healthcare facilities. This is indicative that evidence based practices are not used consistently.

Through project 1.10 BHS will develop the infrastructure, provide training to all levels of staff, and establish a mechanism for employee input. In project 2.8, BHS will define key safety, quality and
Identifying and improving processes that reduce clinical variation supports the goals of Texas Waiver 1115, specifically, improving outcomes and containing costs, health systems can identify and eliminate waste and non-value added steps. Applying lean concepts, these goals can be achieved.

Based on data assimilated and evaluated in DY1, BHS will prioritize to reduce variation in process and/or clinical variation including bowel procedures, congestive heart failure, and top volume ER diagnosis. Reduction in variation as compared to DY1. Each year additional clinical process or practices will be analyzed through lean infrastructure and employee/physician suggestions.

This project certainly is in accord with national initiatives such as Accountable Care organizations. This project is aligned with the Triple AIM Goals:

- Improving patient flow and infrastructure processes increases access for all patients including Medicaid and uninsured patients
- Improving flow and processes contributes to a more coordinated delivery system
- Improving flow and processes, reducing variation and increasing care reliability improves patient safety and outcomes and reduces costs, eliminating waste from system

The project will involve the following core components:

a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.

b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

c) Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures (i.e. weekly or monthly dashboard).

d) Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.

e) Implement software to integrate workflows and provide real-time performance feedback.

f) Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators

This project also aligns with the RHP 6 Community Needs Assessment by improving access, outreach and care for the areas’ underserved, diseased patient population by equipping BHS leaders and staff and improving the care provided and reduce clinical and process variation while reducing the cost of care. This supports CN1 as noted above and will provide eventual benefit to the other community needs.

**Related Category 3 Outcome Measure(s):**

IT- 3.2 Congestive Heart Failure 30 day readmission rate (Stand Alone Measure)
IT- 3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Stand Alone Measure)

Cardiovascular disease is the largest cause of preventable death in Texas in RHP6. Texas is rated “weak” in heart disease.
**Relationship to other Projects:**

This project is related to project 1.1.0, Enhance Performance Improvement and Reporting Capacity. Performance improvement tools can also be used to analyze the data collected as well as develop an improvement plan for improving patient access to Primary Care (1.1), Specialty Care (1.9). Project 2.8 could support 2.3 to redesign primary care, as well as 2.4 redesign to improve patient experience. Lean tools can be utilized to improve cycle times in facilities and clinics and improve patient flow and experience by identifying constraints, wastes, and non-value-added steps as viewed from the patient’s perspective.

This project supports the goals of Texas Waiver 1115, specifically to Improve outcomes while containing cost growth. It is aligned with category 4 projects in that both congestive heart failure and the emergency department are areas of focus to reduce variation in care processes. Lean tools focus on reducing undesirable variation in clinical practices which supports the triple aim concept of optimizing the health system and system integration.

**Relationship to Other Performing Providers’ Projects in the RHP:**

University, Baptist, Methodist Health systems have all cited 2.8 Apply Process Improvement Methodology as a DSRIP Initiative. Material opportunity exists to share findings and results and work collaboratively to improve clinical care and patient outcomes in RHP 6.

**Plan for Learning Collaborative:**

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

**Project Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, Baptist took into account the extent to which Apply Process Improvement Methodology would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The use of PI to improve patient outcomes and experience will help address a substantial need in the community since Texas quality of care has been rated as weak particularly in cardiac care is the #1 cause of death in. It also advances the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because early intervention and chronic disease management are cost effective methods to increase health outcomes.
### Pass 1

**Related Category 3 Outcome Measure(s):**
- 159156201.3.6
- 159156201.3.7

**Goal:** Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency

#### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
- Milestone 1 Estimated Incentive Payment: $1,137,296

**Metric 1 [P-4.1]: [Report on at least two operational procedures needed to improve overall efficiencies in care management]

**Baseline is identify two procedures each for bowel surgery and CHF**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool

**Milestone 2**

**Metric 1 [P-3.1]: [Submission of analysis findings/summary and identification of target area]

**Baseline is identification of an incremental clinical area, procedure or process for improvement to DY2 procedures (bowel surgery and CHF)**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool

#### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3**
- Milestone 3 Estimated Incentive Payment: $2,481,459

**Metric 1 [P-3]: Compare and analyze clinical/quality/data and identify at least one “additional” area for improvement**

**Baseline is compare and analyze clinical/quality/data and identify at least one “additional” area for improvement**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool

#### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4**
- Milestone 4 Estimated Incentive Payment: $1,244,336

**Metric 1 [I-13.1]: [Number of relevant clinical cases at target] Goal is 10% improvement in measure outcomes for bowel surgery and CHF identified in DY2**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool

#### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 5**

**Metric 1 [I-13]: [Number of relevant clinical cases at target] Goal is 20% improvement in measure outcomes for bowel surgery and CHF identified in DY2**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool

**Milestone 6**
- Milestone 6 Estimated Incentive Payment: $2,055,860

**Metric 1 [I-13]: [Number of relevant clinical cases at target] Goal is 20% improvement in measure outcomes for bowel surgery and CHF identified in DY2**

**Data Source:** Avega, Crimson, Operational Improvement Department Tracking Tool
| [P-6] Implement a program to improve efficiencies and/or reduce program variation |
| Metric 1 [P-6.1]: (Performance improvement events for surgical services) Baseline is incremental events for surgery performed in DY2 |
| Data Source: Avega, Crimson, Operational Improvement Department Tracking Tool |
| Milestone 2 Estimated Incentive Payment: 1,137,297 |

| and/or cost |
| Metric 1 [I-14.1]: (Demonstrate 10% Performance improvement in efficiency and/or cost for surgical services events identified in DY2 and improved upon) Baseline is incremental cost or efficiencies to the analysis in DY2 |
| Data Source: Avega, Crimson, Operational Improvement Department Tracking Tool |
| Milestone 5 Estimated Incentive Payment: $1,244,336 |

| Year 2 Estimated Milestone Bundle Amount: $2,274,593 |
| Year 3 Estimated Milestone Bundle Amount: $2,481,459 |
| Year 4 Estimated Milestone Bundle Amount: $2,488,672 |
| Year 5 Estimated Milestone Bundle Amount: $2,055,860 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $9,300,584
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>2.1.2 – Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients: Patient-Centered Medical Home</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>020844901.2.1 – PASS 1</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>CHRISTUS Santa Rosa Health System</td>
</tr>
<tr>
<td>TPI:</td>
<td>020844901</td>
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</tbody>
</table>

### Project Summary:

**Provider Description:** CHRISTUS Santa Rosa Health System (CSRHS) is a Catholic, non-profit health and wellness system with three adult acute care hospitals, one short-stay surgical hospital, two free standing emergency departments and several physician joint-venture ambulatory surgery centers. With a combined total of 496 beds, CSRHS currently serves the San Antonio and New Braunfels markets which has a total population of 1.9 million.

**Intervention(s):** This project will increase access to primary care and improve the management of chronic diseases in the community by contributing to the expansion of medical homes. The innovative nature of this project centers on the fact that this PCMH involves the integration of multiple, small practices who together act as a single, large integrated PCMH.

**Need for the project:** CSRHS is currently piloting a medical home model with nine practices for its employees. This project will allow CSRHS to increase the number of medical homes and improve access and quality for the targeted patient population.

**Target population:** The target population is ethnically diverse, low-income Medicare and Medicaid beneficiaries who have significant impediments to accessing primary care. Hospital utilization data from the previous two fiscal years reveals that almost 39% of inpatient admissions for CSRHS are from the Medicare fee-for-service population. Furthermore, this target population is a key driver for CSRHS’ 30-day readmissions: 62% of all heart failure readmissions, 57% of acute myocardial infarction readmissions and 39% of pneumonia readmissions are Medicare beneficiaries. In fact, this target population is a substantial driver for 30-day readmissions for any diagnosis. While the target population only accounts for 10% of Emergency Department visits, almost half (46%) of those visits become inpatient admissions. The Bexar County Community Needs Assessment revealed that almost one-third (33%) of Bexar county residents do not have a medical home or even a primary care physician that oversees their care. Data from internal hospital registrations during 2011 revealed that 1,475 Medicare inpatients did not have a primary care physician or medical home.

**Category 1 or 2 expected patient benefits:** This project seeks to increase the number of medical homes available to Medicare and Medicaid beneficiaries by 8 between DY2 and DY5 (2 per year). Additionally this project will increase the number of patients assigned to medical homes by 24% (2,136) over baseline in DY3; 19% (2,097) increase in DY4; and 15% (1,970) in DY5. Finally, all participating medical homes will seek NCQA medical home recognition, with the goal of having all medical homes established between DY2 and DY4 NCQA accredited by DY5. CSRHS expects that approximately 5% of the patients served by these medical homes will be Medicaid or indigent.
Category 3 outcomes: [IT-1.10] The goal is to improve HbA1c levels for the targeted population in DY4 and DY5. Targets will be determined based on the baseline established in DY3.

**Project Description:**
CHRISTUS Santa Rosa Health System (CSRHS) will take an innovative approach to the Patient-Centered Medical Home (PCMH) by partnering with small, independent, geographically distributed primary care practices to create an integrated care delivery model that improves access to primary care (CN.3) for this vulnerable population group. This project addresses demonstrated public health challenges in the community by catering to the complex, chronic care needs (CN.2) of the population 65 and older; improving patient adherence to care plans through comprehensive preventive and primary care services; providing active follow-up in-between office visits; and, promoting continuity of care. The target population is ethnically diverse, low-income Medicare beneficiaries who have significant impediments to accessing primary care.

**Goals and Relationship to Regional Goals:**
The goal of this project is to improve quality access to primary care in the community by contributing to the expansion of medical homes. The innovative nature of this project centers on the fact that this PCMH involves the integration of multiple, small practices who together act as a single, large integrated PCMH.

**Key Goals:**
1) Support the ongoing relationship between the patient a personal physician who provides continuous, comprehensive care;
2) Care to be provided by a team which includes primary care physicians, nurse practitioners, dieticians, care coordinators, mental health experts, who collectively take responsibility for patient needs, whether within the practice or through referral;
3) Care that is coordinated and/or integrated across all elements of the health care system and the patients community;
4) Care that is facilitated by the use of data registries, information technology, health information exchange, and other systems to assure that patients get care when and where they need it;
5) Expanded access to health practitioners through open scheduling and expanded hours;
6) Provide a reimbursement structure that supports and encourages this model of care.

This project meets the following regional goals:

- **Triple Aim:** assuring patients receive high-quality and patient-centered care, in the most cost effective ways.
- **Improve the healthcare infrastructure to better serve Medicare, Medicaid and uninsured residents of our counties.**
- **Further develop and maintain a coordinated care delivery system**
- **Improve outcomes while containing cost growth.**

**5-Year Expected Outcome for Provider and Patients:**
As a result of this project, we expect to see a marked increase in access to primary care for this population and a significant improvement in the management of chronic conditions over the next 5 years.

In the implementation of this project, CSRHS will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, CSRHS will ensure that all medical homes make ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for patient-centered medical homes.

**Starting Point/Baseline:**

As of December 1, 2011, nine medical home participating groups were identified as a starting point to develop this project. The nine medical homes currently serve approximately 8,900 active Medicare beneficiaries. The plan is to expand this PCMH network by 4-6 practices.

*Source: CHRISTUS Santa Rosa Internal Data*

**Rationale:**

According to the Region 6 Community Needs Assessment, limited access to primary care (CN.3) and chronic disease management (CN.2) are amongst the major challenges facing the population. These challenges will be exacerbated as the population continues to grow and more Texans gain access to health care coverage under the Affordable Care Act. There is a growing body of research that concludes that PCMHs deliver more affordable, better quality primary care. Recent evaluations conducted across 20 states shows evidence of better outcomes, reduced mortality, fewer preventable hospital admissions, lower acute care utilization, improved patient compliance with recommended care and lower spending.

As previously stated, the target population for this project is ethnically diverse, low-income and has significant impediments to accessing comprehensive primary care. Hospital utilization data from the previous two fiscal years reveals that almost 39% of inpatient admissions for CSRHS are from the Medicare fee-for-service population. Furthermore, this target population is a key driver for CSRHS’30-day readmissions: 62% of all heart failure readmissions, 57% of acute myocardial infarction readmissions and 39% of pneumonia readmissions are Medicare beneficiaries. In fact, this target population is a substantial driver for 30-day readmissions for any diagnosis. While the target population only accounts for 10% of Emergency Department visits, almost half (46%) of those visits become inpatient admissions. The Bexar County Community Needs Assessment revealed that almost one-third (33%) of the Bexar county residents do not have a medical home or even a primary care physician that oversees their care. Data from internal hospital registrations during 2011 revealed that 1,475 Medicare inpatients did not have a primary care physician or medical home.

The PCMH Project involves the collaboration of affiliated patient-centered medical homes to integrate care management and coordination for shared, high-risk patients. The core project components include:

a) **Improve data exchange between hospitals and affiliated medical home sites:** hospital affiliated medical home sites will implement a common data exchange process where practice performance relative to agreed upon quality metrics and protocols can be monitored to ensure compliance.

b) **Develop best practices plan to eliminate gaps in the readiness assessment:** As part of achieving NCQA certification for each practice, a readiness assessment will be completed...
and any gaps identified in the assessment will be addressed as part of the process to meet the required NCQA criteria.

c) *Hire and train team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients:* The medical home project will be hiring and/or leveraging other allied health providers to support the needs of each medical home practice to assure that identified high risk patients are appropriately managed to reduce unnecessary utilization of healthcare resources and to improve patient outcomes.

d) *Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients:* The medical home project will have a comprehensive care coordination program, the purpose of which is to identify high risk patients in each practice, establish a relationship with each high risk patient, assure that each identified patient is following the medical intervention plan, the result of which will be to reduce unnecessary utilization, and improve the health of the patient.

e) *Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvements to improve the intervention:* The medical home network will be collecting data on all medical home patients for all participating practices on utilization of services, both outpatient and inpatient, and these data will be compared to establish baseline utilization to determine whether improvements have occurred in the utilization of healthcare services for high risk patients.

f) *Conduct quality improvement for project using methods such as rapid cycle improvement.* Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” identifying opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. We will implement a system that allows us to track the number of patients, types of patients, utilization of inpatient and outpatient resources, patient outcome measures, which will provide us data to measure performance and initiate rapid cycle changes to continually improve our processes.

Three major milestones were selected to ensure that this project achieves the intended results:

1) **Implement the medical home model in primary care clinics:** Increasing the number of PCMHs to serve this project is critical to the goal of expanding primary care access.

2) **Improve the number of eligible patients that are assigned to the medical homes:** Increasing the number of patients enrolled in this project will be critical to having a true impact on managing this population.

3) **Implement PCMH NCQA standards into every medical home:** Achieving NCQA recognition will ensure that this model delivers high quality and efficient care.

This project meets the Triple Aim goals of the Waiver by promoting better health, better patient experience of care, and ultimately better cost-effectiveness. The PCMH model is a foundation for the ability to accept alternative payment models under payment reform and deliver care aligned with payment reform models. By providing the right care at the right time and in the right setting, patients not only have better access to primary care, they may see their health improved, will rely less on costly ED visits, will incur fewer avoidable hospital stays and report greater
patient satisfaction.

Unique community need identification numbers the project addresses:

- CN.2 – High prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions.
- CN.3 – Lack of access to medical and dental care due to high rates of uninsurance and health care providers shortages.

How the project represents a new initiative or significantly enhances an existing deliver system reform initiative:

CSRHS is currently piloting a medical home model with nine practices for its employees. This project will allow CSRHS to increase the number of medical homes and improve access and quality for the targeted patient population.

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
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<tbody>
<tr>
<td>OD-1 Primary Care and Chronic Disease Management</td>
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<tr>
<td>IT-1.10 Diabetes Care: HbA1c Poor Control</td>
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</table>
  - Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (Hba1c) control >9.0% |

Reasons/rationale for selecting the outcome measures:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. According to the RHP community needs assessment (CN.2); a high prevalence of chronic disease and related health disparities requires greater prevention efforts and improved management of patients with chronic conditions. A major goal of this project is to improve adherence to care plans by offering comprehensive preventative and primary care services that cater to the complex, chronic care needs of the population 65 and older. By using the HbA1c improvement target for this project, providers can focus on controlling this population’s diabetes; will drastically improve the health of this population, while also helping to reduce costs.

Relationship to other Projects:

Through the PCMH model, primary care office hours are expanded, which helps to expand Primary care capacity (1.1); The PCMH focuses on chronic disease management, which reinforces project Expand Chronic Care Management Models (2.2); The basic concept behind the PCMH is to redesign how primary care is delivered, which reinforces project Redesign Primary Care (2.3); a direct outcome of the PCMH is patient satisfaction, which support project Redesign to Improve the Patient Experience (2.4); and through the implementation of standard protocols and achieving NCQA recognition, the PCMH model will improve quality and efficiency (2.8).

Relationship to Other Performing Providers’ Projects in the RHP:

Nix Healthcare System
Plan for Learning Collaborative:

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

Project Valuation:

The valuation of CHRISTUS projects use a method which ranks the importance of each project based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Medical homes are one of the most effective and proven methods to coordinate primary care and lower costs by reducing unnecessary or duplicative medical procedures - thus medical homes will allow CHRISTUS Santa Rosa to directly address one of the three main goals of the Waiver. Additionally, Region 6 has a demonstrated need for an increase in primary care capacity, which is mitigated by the establishment of medical homes.
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<tr>
<th>020844901.2.1 PASS 1</th>
<th>2.1.2</th>
<th>2.1.2.A THROUGH F</th>
<th>2.1.2 Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients: Patient-Centered Medical Home</th>
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**Related Category 3 Outcome Measure(s):**

<table>
<thead>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics using medical home model
Baseline: 9 existing PCMHs
Goal: Increase by 2
Data Source: Newly signed letters of agreement

**Milestone 1 Estimated Incentive Payment:** $995,135

**Milestone 2**
P-2: Put in place policies and systems to enhance patient access to the medical home.
**Metric 1:** Performing provider policies on medical home
Baseline/Goal: original 9

**Milestone 3**
I-12: Based on criteria, improve the number of eligible patients that are assigned to the medical homes
**Metric 1** I-12.1: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the performing provider.
Baseline/Goal: Increase by 24% (2,136)
Data Source: Practice Management System or EHR

**Milestone 3 Estimated Incentive Payment:** $723,759

**Milestone 4**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 5**
I-12: Based on criteria, improve the number of eligible patients that are assigned to the medical homes
**Metric 1** I-12.1: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the performing provider.
Goal: Increase by 19% (2,097)
Data Source: Practice Management System or EHR

**Milestone 5 Estimated Incentive Payment:** $725,863

**Milestone 6**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 7**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 8**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 9**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 10**
P-1: Implement the medical home model in primary care clinics.
**Metric 1** P-1.1: Increase number of primary care clinics

**Milestone 10 Estimated Incentive Payment:** $599,626
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<th>Milestone</th>
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**Milestone 5**
- I-18: Obtain medical home recognition by a NCQA
- Metric 1 I-18.1: Medical home recognition/accreditation
- Goal: Achieve NCQQ recognition for each practice established in DY2
- Data Source: Documentation of recognition/accreditation from NCQA

**Milestone 8**
- I-18: Obtain medical home recognition by a NCQA
- Metric 1 I-18.1: Medical home recognition/accreditation
- Goal: Achieve NCQQ recognition for each practice established in DY3
- Data Source: Documentation of recognition/accreditation from NCQA

**Milestone 11**
- I-18: Obtain medical home recognition by a NCQA
- Metric 1 I-18.1: Medical home recognition/accreditation
- Goal: Achieve NCQQ recognition for each practice established in DY4
- Data Source: Documentation of recognition/accreditation from NCQA

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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,138,011**
### Identifying Project and Provider Information:

<table>
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<tr>
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<tr>
<td>Provider Name: CHRISTUS Santa Rosa Health System</td>
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<td>TPI: 020844901</td>
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### Project Summary:

**Provider Description:** CHRISTUS Santa Rosa Health System (CSRHS) is a Catholic, non-profit health and wellness system with three adult acute care hospitals, one short-stay surgical hospital, two free standing emergency departments and several physician joint-venture ambulatory surgery centers. With a combined total of 496 beds, CSRHS currently serves the San Antonio and New Braunfels markets which has a total population of 1.9 million.

**Intervention(s):** The goal of this project is to implement a post-discharge transitions program to help patients make a smooth transition from the inpatient to the post-acute setting. This project will create smooth transitions of care from inpatient to outpatient settings or to alternative post-acute settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.

**Need for the project:** Currently, this program does not exist at CSRHS. By implementing this intervention, CSR will improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.

**Target population:** This project will focus on patients with the Principal diagnosis of congestive heart failure (CHF), pneumonia (PN) and acute myocardial infarction (AMI). Nearly 11% of the population in this service area is over the age of 65, which is the age cohort most often diagnosed with these conditions.

**Category 1 or 2 expected patient benefits:** In the most recent 12 months, CSRHS has had an estimated 3,692 patients grouped under one of these principle diagnosis codes. This will be a new project that seeks to have 74 patients participating in the discharge planning program by in DY3, an additional 75 in DY4, and an additional 77 in DY5. CSRHS expects that approximately 10% of the patients served will be Medicare, Medicaid or indigent.

**Category 3 outcomes:** [IT-3.2] The goal is to decrease the Congestive Heart Failure 30 day re-admission rate. Targets will be determined based on the baseline established in DY3.

### Project Description:

The goal of this project is to implement a post-discharge transitions program to help patients make a smooth transition from the inpatient to the outpatient setting. This project will create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.

There is a growing body of evidence that suggests discharge planning that begins at the time of admission to the hospital, coupled with customized, focused education and programmatic follow up for 30 days post discharge, will prevent or reduce the number of unplanned re-admissions to...
the hospital. Ineffective discharge planning, instruction and follow up for the inpatient population results in patient non-compliance with prescribed care regimen and often results in re-admission to the hospital. There are a number of well designed, proven discharge planning/care transitions programs available for use in the hospital setting. This project will utilize the Care Transitions Intervention designed with funding from the John A Hartford and the Robert Wood Johnson Foundation. The Care Transitions Intervention was designed in response to the need for a patient-centered, interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners.

The model is composed of the following components: A patient centered record that consists of the essential elements for facilitating productive interdisciplinary communication during the care transition referred to as the "Personal Health Record." A structured checklist, the "Discharge Preparation Checklist" of critical activities designed to empower patients before discharge from the hospital. A patient self-activation and management session with a "Transitions Coach" in the hospital, designed to help patients and family understand and apply the first two elements. And, finally Transition Coach follow up visits to the home and/or Skilled Nursing Facility as well as accompanying phone calls to sustain the first three components and provide continuity across the transition.

The Care Transitions Intervention focuses on four conceptual areas, referred to as the Four Pillars: 1. Medication Self-Management 2. Dynamic Patient Centered Record 3. Follow-up and 4. Red Flags. The Transitions Coach is an RN trained in the Care Transitions Intervention program to be adept at the use of the tools and the process.

Goals and Relationship to Regional Goals

The overall goal will be to reduce unplanned re-admissions for targeted patient populations, specifically congestive heart failure, pneumonia and acute myocardial infarction. Unplanned re-admissions are costly to the provider, our government and to the patient/consumer. Unplanned, avoidable re-admissions consume a significant amount of healthcare resources and can be reduced if discharge planning is done in a comprehensive, coordinated manner in which the patient and family are empowered through knowledge to successfully manage their disease. The successful implementation of the Care Transitions Intervention will reduce health care costs for the RHP, CHRISTUS Santa Rosa and the patient and family.

This project meets the following regional goals:

- Triple Aim: assuring patients receive high quality and patient-centered care, in the most cost effective ways
- Further develop and maintain a coordinated care delivery system
- Improve Outcomes while containing cost growth.

5-Year Expected Outcome for Provider and Patients:

As previously stated, the primary goal of this project is to significantly reduce unplanned re-admissions for targeted patients populations. The project will be piloted at the CHRISTUS Santa Rosa New Braunfels campus with a focus on patients with the Principal diagnosis of congestive
heart failure (CHF), pneumonia (PN) and acute myocardial infarction (AMI). Once successfully implemented at New Braunfels, this program will be implemented at each adult campus.

In the implementation of this project, CSRHS will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, CSRHS will ensure that its care transitions program makes ongoing efforts to meet or exceed all nationally recognized protocol or quality benchmarks for care transitions/discharge planning.

### Starting Point/Baseline:

As of June 30, 2012 the regional, "predicted" re-admission rate (as provided and calculated by CMS as part of the Value Based Purchasing reporting) is as follows: AMI - 19.7%  CHF - 22.3%  PN - 15.6%. As the number of patients receiving enhanced, appropriate discharge and follow up care increases, it is anticipated that these readmission rates will decrease.

### Rationale:

When a patient’s transition from the hospital to home is less than optimal, the repercussions can be far-reaching – hospital readmission, an adverse medical event, and even mortality. MedPAC estimates that the US spends $17.4 billion annually for Medicare re-admissions. Of that amount, an estimated $14 billion is attributed to avoidable re-admissions. It is estimated that 18% of Medicare patients are re-admitted within 30 days.

According to the Community Needs Assessment, the state of Texas ranks last in the nation on health care quality. Furthermore, RHP 6 has identified chronic disease as a key issue that must be addressed. The evidence demonstrates that re-admissions in these patient populations can be prevented when patients and families are appropriately educated, when patients and families participate in the creation of their discharge plan, when assistance is provided to assure that the necessary post discharge services are available to the patient and family and when follow - up assistance is provided to assure that the discharge plan is being followed. With an organized and consistent approach to discharge in these populations deteriorating conditions can be identified early and appropriate interventions can be utilized to improve condition and prevent expensive re-admission. Additionally, beginning in federal FY 2013 hospitals will be at risk for up to a 1% reduction in all Medicare payments if they fail to reduce re-admission rates in the heart failure, pneumonia and heart attack patient populations. From a quality of care perspective, low re-admission rates correlate with overall clinical excellence as evidenced in a number of studies and databases. A focus on a well planned, well coordinated and well communicated discharge plan will improve the coordination and effectiveness of care and care transition from hospital to home or skilled nursing facility.

This project will involve the development, implementation and evaluation of standardized protocols and evidence-based care delivery to improve care transition. The core components are as follows:

a) **Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.);** the proposed program adapt evidence-based best practices from other similar programs to assure smooth program implementation and to achieve improvements in readmission rates.

b) **Analysis of the key drivers of 30-day readmissions using a chart review tool (e.g. the**
Institute for Healthcare Improvements (IHI) State Action on Avoidable Re-hospitalizations (STAAR tool) and patient interviews: This program will build in a comprehensive data collection and review process to allow us to assess adherence to program objectives and to monitor impact to readmissions on an ongoing basis.

c) Integration of information systems so that continuity of care for patients is enabled: The program will utilize the hospital’s existing information systems to coordinate the inpatient and post acute care process, so that all caregivers are aware of the patient’s status and compliance with discharge instructions.

d) Development of a system to identify a patient being discharged potentially at risk of needing acute care services within 30-60 days: The program will utilize the hospital’s existing information systems to coordinate the inpatient and post acute care process, so that all caregivers are aware of the patient’s status and compliance with discharge instructions.

e) Implementation of discharge planning program and post discharge support program: the program contemplates developing a comprehensive discharge planning and post discharge support component, which will use information systems to maintain patient data and monitor results.

f) Development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers: program will put in place a full continuum of post acute services where post and hospital caregivers can effectively communicate about patient status post discharge to avoid potential readmissions to the hospital.

g) Quality improvement for using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned”, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations: we will implement a system that allows us to track the number of patients, types of patients, utilization of inpatient and outpatient resources, patient outcome measures, which will provide us data to measure performance and initiate rapid cycle changes to continually improve our processes.

Three major milestones were selected to ensure that this project achieves the intended results:

1) Implement standardized care transition process: The goal is to implement this process in a total of three hospitals between DY2 through DY5. The first implementation will occur in DY2, with the next two occurring in DYs 4 and 5.

2) Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program: a critical component to the success of this project will be staff training. This metric will ensure that an appropriate plan is established and implemented to ensure successful project implementation.

3) Implement standard care transition process in specified patient populations: this metric will provide the number of patients in a defined populations receiving care according to the implemented protocol.

Unique community need identification numbers the project addresses:

- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
• CN.2 – A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.

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

Currently, this program does not exist at CSRHS. By implementing this intervention, CSR will improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.

Related Category 3 Outcome Measure(s):

OD-3 Potentially Preventable Re-admissions – 30 day readmission rates

IT-3.2, Congestive Heart Failure 30 Day Readmission Rate

• The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission.

Reasons/rationale for selecting the outcome measures:

The relationship between hospital readmission rates and quality of care is well-documented. This project is focused on improving care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from the hospital to home. There is a growing body of evidence that suggests discharge planning that begins at the time of admission to the hospital, coupled with customized, focused education and programmatic follow up for 30 days post discharge will prevent or reduce the number of unplanned hospital re-admissions. Congestive Heart Failure is one of the principal diagnoses that will be targeted in this program, which makes this improvement target a suitable measurement.

Relationship to other Projects:

The Care Transitions – Intervention Nurse Program supports/reinforces several Category 1 and 2 projects: there is a significant focus on chronic disease management (1.3 & 2.2); this project will create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions; which supports the primary goals of project (2.4) Redesign the Patient Experience and (2.8) Apply Process Improvement Methodology to Improve Quality/Efficiency, and it helps patient become more involved in their own health care which reinforces the primary objective of (2.14) Implement person-centered wellness self-management strategies and self directed financing models that empower consumers to take charge of their own health care.

Relationship to Other Performing Providers’ Projects in the RHP:

Guadalupe Regional Medical Center
Plan for Learning Collaborative:

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

Project Valuation:

In valuing this project, CHRISTUS Santa Rosa took into account the extent to which a transition of the care program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it would address the community needs, the population served, and resources and cost necessary to implement the project.

A program to support discharge planning will meet one of the three main goals of the Waiver by coordinating care. This type of coordination has the long term goal of reducing unnecessary healthcare costs by preventing future hospitalization due to inappropriate post-discharge placement. This project would also meet a specific need in the community to coordinate care and promote primary care.
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<th>020844901.2.2 PASS 1</th>
<th>2.12.1</th>
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636 ★ RHP Plan ★ March 8, 2013 ★ CHRISTUS Santa Rosa Health System
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| Year 2 Estimated Milestone Bundle Amount: $852,972 | Year 3 Estimated Milestone Bundle Amount: $930,547 | Year 4 Estimated Milestone Bundle Amount: $933,252 | Year 5 Estimated Milestone Bundle Amount: $770,947 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,487,719**
Identifying Project and Provider Information:

| Title: 2.12.2 Implement/Expand Care Transitions Program |
| Unique RHP ID#: 138411709.2.1 –PASS 1 |
| Performing Provider: Guadalupe Regional Medical Center |
| Performing Provider TPI: 138411709 |

Project Summary:

Provider Description: Guadalupe Regional Medical Center is a 125 bed facility in Seguin, Texas serving a population of approximately 100,000 in 8 counties. Intervention(s): The project would implement improvements in transitioning patients and coordination of care from inpatient to outpatients, post-acute care, and home care settings. The Transitional Care Program will institute an evidence based risk assessment tool to identify patients who are at highest risk for 30 Potentially Preventable Re-admissions/Admissions (PPR/PPA). The Transitional Care program will provide for a trained Transitional Care Coordinator as well as established policies and procedures. The goal will be to proactively educate the targeted population, monitor and support them through the discharge process to the home, and ensure necessary resources are referred.

Need for the project: There is currently no existing community program with dedicated resources designed to act as a patient advocate and liaison in transition from acute care to the home. The Transitional Care Program will improve the quality of life of the service area as well as reduce costs by implementing strategies to promote both wellness and patient empowerment. These initiatives will reduce the financial impact of potentially preventable admissions, potentially preventable re-admissions, and ER visits.

Target population: GRMC has a CHF readmission rate in the fourth (worst) quartile in the state of Texas for the period of 2006-2009, as publicly reported by CMS. GRMC will develop a Transitional Care Program to assist with care transitions and medication management Targeting patients with a primary diagnosis of CHF, COPD, DM, Pneumonia, as well as being highly sensitive to those uninsured, covered by Medicaid, or at / below the 2012 HHS poverty level. Based on the capture diagnosis listed above we anticipate serving approximately 540 patients. The high risk patients, as determined by completion of a High Risk Assessment Tool, will add approximately 220 patients per year. An estimated 15-20% of patients served are expected to be Medicaid/Indigent.

Category 1 or 2 expected patient benefits: The project seeks to develop and institute a Transitional Care program, establish baselines, and utilize an evidence based screening tool by DY2. By DY 5 we also seek to increase patients enrolled and served by the GRMC Transitional Care Program by 35% from the year 2 baseline.

Category 3 outcomes: IT-3.1- All cause 30 Day readmission Rate - Our goal is to Achieve a 5% reduction from baseline in unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group by DY5.
Project Description:

**Guadalupe Regional Medical Center seeks to implement / expand a Care Transitions Program**

The project would implement improvements in transitioning patients and coordination of care from inpatient to outpatient, post-acute care, and home care settings. The Transitional Care Program will institute an evidence based risk assessment tool to identify patients who are at highest risk for 30 Potentially Preventable Re-admissions/Admissions (PPR/PPA). The Transitional Care program will provide for a trained Transitional Care Coordinator as well as established policies and procedures. The goal will be to proactively educate the targeted population, monitor and support them through the discharge process to the home, and ensure necessary resources are referred.

The Transitional Care Team has the potential to institute the LACE risk assessment tool on all target population patients. The Transitional Care program will ensure identified target population high risk patients are referred to the Transitional Care Program. Through the intervention of the program via the dedicate health care worker ((Transitional Care Coordinator) we will have a material positive effect on the PPA and PPR.

GRMC has a CHF readmission rate in the fourth (worst) quartile in the state of Texas for the period of 2006-2009, as publicly reported by CMS. GRMC will develop a Transitional Care Program to assist with care transitions and medication management of CHF, COPD, DM, and Pneumonia patients. This program will include: a dedicated resources which will utilize and/or facilitate:

- Discharge checklists
- Hand off communication tools
- Pre and post-discharge medication reconciliation/management plans
- Weight and blood pressure monitoring
- A focus on health literacy and teach back
- Physician appointment assistance and monitoring
- Coordination of community resources
- In home and phone follow-up
- Quarterly meetings with local nursing homes and assisted living facilities in order to discuss identified problems
- Solve issues related to avoidable hospital admission/readmission

We propose to target the communities serviced by Guadalupe Regional Medical Center. This has historically been Seguin and adjacent communities with Guadalupe and Adjacent Southern county populations.

**Goals and Relationship to Regional Goals:**

The Transitional Care Program at Guadalupe Regional Medical Center seeks to promote the Triple Aim of improving the health of our population, enhancing the patient experience of care, and reducing the per capita cost of care. Through the development of a Transitional Care program, targeting patients with a primary diagnosis of CHF, COPD, DM, Pneumonia, as well as being...
highly sensitive to those uninsured, covered by Medicaid, or at / below the 2012 HHS poverty level, GRMC will have a positive material effect on said Triple Aim goals. GRMC has identified a gap in care transitions that create potentially preventable readmissions. Through a Transitional Care Coordinator and established policy and procedures GRMC will educate the targeted population, monitor and support through the discharge process to the home, and ensure necessary resources are referred.

Project Goals:

- As this project moves forward GRMC will identify and implement appropriate best practices from the Partnership for Patients (P4P) initiative- Texas Healthcare Engagement Network (HEN) as well as from other programs and models of care documented in the literature.
- Increase number of patients enrolled in Transitional Care Program
- Reduce % of target population PPA and PPR

This project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- This project address RHP 6 goals by: “serving those who are low income or without insurance and or Suffering with a chronic disease which increases the likelihood of preventable admissions and preventable re-admissions”. The transitional Care Program will also address the goal of improving access to primary and specialty care, as well as improving the management of patients with chronic disease. This will be accomplished by having dedicated resources, evidence based identification tools, established policy and procedures, and post hospital follow up / monitoring protocols.

Challenges:

Communication of patient needs between the acute care setting and post-acute care setting is challenging. Additionally, patients discharged home may have difficulty following discharge instructions due to lack of understanding and/or a lack of resources and access. Focus on Health literacy within the service area has not been traditionally targeted. The primary challenge for this project will be to engage and build trust with patients. Targeted communities have historically been difficult to penetrate, but with proper interdisciplinary training, and oversight by a dedicated team, the project has a high likelihood of success. In particular, cultural competency training and the involvement of a variety of innovative provider types within the care team will ensure GRMC addresses the full spectrum of the participants’ needs.

5-Year Expected Outcome for Provider and Patients:
- The 5 year expected outcome is a 35% increase from year 2 baseline in patients enrolled and served by the GRMC Transitional Care Program.
- Decrease the number of PPA and PPR by 5% in year 5.

**Starting Point/Baseline:**

The pilot Transitional Care Program began on July 17, 2012 and as of October 3rd there were 21 patients being followed by the Transitional Care Coordinator. The patients were referred to this program through the GRMC Inpatient Case Management Department. During this time period the Transitional Care Coordinator has performed the following patient encounters: 10 visits in the hospital setting, 6 post-hospitalization visits in the home, and 50 post-discharge phone calls. To date (9/24/12) there have been no readmissions among this group of patients.

The GRMC Transitional Care Program currently consists of one RN who reports to the Director of Home Health Services. Due to the infancy status of this program less than 2% of the hospital nurses have been educated about the process. Likewise, less than 2% of the hospitalists and primary care physicians have been educated to date.

**Rationale:**

Guadalupe County has a largely rural service area with an established population possessing morbidities and co-morbidities which have significant potential for causing unnecessary utilization of Emergency Room and inpatient services. These morbidities include (but are not limited to) CHF, COPD, DM and pneumonia. In addition, limited public transportation, a high number of un/under-insured, and serious gaps in health literacy increase the potential for non-compliance with medication regimens and follow-up care. Also, The Transitional Care Programs at GRMC will serve to compensate for the health provider shortage identified in Guadalupe County. The GRMC Transitional Care program is starting in the early stages of development.

GRMC will develop a Transitional Care Model (TCM) which will address Unique Community Need CN.2 - A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes. The model will integrate transitional care into the discharge process thereby ensuring the identified population is proactively educated on their chronic disease and prepared prior to discharge home. Patients identified as high risk for readmission or Emergency Room visits will be referred to the Transitional Care Coordinator who will monitor the patient for at least thirty days after discharge from the hospital. This intervention may involve phone calls and/or home visit follow-up and assistance with medication management and the scheduling of primary care appointments based upon individual patient situation and need.

The GRMC Transitional care model is in its early stages of development. There is currently no existing community program with dedicated resources designed to act as a patient advocate and liaison in transition from acute care to the home. The Transitional Care Program will improve the quality of life of the service area as well as reduce costs by implementing strategies to promote both wellness and patient empowerment. These initiatives will reduce the financial impact of potentially preventable admissions, potentially preventable re-admissions, and ER visits. These
reductions will contribute to improvement in the quality of life for the patients served. Guadalupe County is expected to recognize continued population growth, which will likely exacerbate current health challenges. These challenges include limited access to primary and specialty care, unmet mental and behavioral health needs, and high prevalence of chronic disease. The projected Medicaid expansion and use of health insurance exchanges may have significant impact on the health status of residents and related outcomes of RHP 6 initiatives. The opportunity to implement transformative projects through the 1115 waiver funding will help RHP 6 address the needs of the GRMC served community.

As part of the CQI core component GRMC will seek to work collaboratively with other providers. Sharing ideas and improving existing practices will be the primary focus of the collaborations. This will be noted in the Year 4 Milestone 3 (P-12.1). In addition, as part of the CQI component, GRMC plans to conduct bi-weekly meetings, conference calls, or webinars organized by the RHP. All webinars, meetings, conference calls etc. will be documented to include copies of agendas, power point slides etc. The investment in learning and sharing of ideas will be central to our goal of continuous learning and improvement.

**Related Category 3 Outcome Measure(s):**

- IT-3.2 Congestive Heart Failure 30 Day readmission rate-Stand-alone measure.

**Reasons/rational for selecting outcome measures**
Demographically the GRMC service area has modest to high incidence of primary and secondary DX of CHF and morbidities relating to complications of CHF. As evidenced by Coleman ("Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs" and Coleman, Parry et al ("The Care Transition Intervention: a patient centered approach to ensuring effective transfers between sites of geriatric care"), best practices have been identified which contribute to the triple aim when applied to patients transitioning from the hospital to their residence. Focusing on this outcome will ensure our target population, with particular interest in those at/below the 2012 HHS poverty line or who are under / uninsured, are appropriately educated, monitored, and connected to applicable and required resources. This will decrease PPA and PPR, thereby reducing cost, increasing patient satisfaction, and improving long term outcomes.

**Relationship to other Projects:**

The implementation of a Transitional Care program will provide the organization with the structure and processes needed to address many key issues related to quality patient care, patient satisfaction, and healthcare cost containment. The Transitional Care Program at GRMC will support the goals identified in the following RHP projects:

- 1.3 – Implement a Chronic Disease Management Registry
- 2.2 – Expand Chronic Care Management Models
- 2.4 – Redesign to Improve Patient Experience
- 2.5 – Redesign for Cost Containment
- 2.6 – Implement Evidence-based Health Promotion Programs
- 2.8 – Apply Process Improvement Methodology to Improve Quality/Efficiency
- 2.10 – Use of Palliative Care Programs
- 2.11 – Conduct Medication Management
- 2.14 – Implement person-centered wellness self-management strategies and self-directed
financing models that empower consumers to take charge of their own health

Furthermore the GRMC Transitional Care plan will support and reinforce the following category 4 population focused measures:

RD-1 - Potentially preventable readmissions-Done through a comprehensive pre-discharge education and post-discharge interaction with emphasis on medication management and physician follow up.
RD-2-Potentially Preventable Admissions-Through community outreach and education provided by the Transitional Care Coordinator we will minimize the likelihood of PPA.
RD-3 -Potentially Preventable Complications- Through follow-up, monitoring, and education pre and post-discharge GRMC will proactively identify and address any areas that may lead to PPC.
RD-4 - Emergency Department-A comprehensive Transitional Care program will ensure the ER is utilized in appropriate fashion. Through the efforts of the transitional care program, mainly in the areas of medication management, resource identification, and appropriate physician follow-up, a reduction in ER utilization is projected.
RD-5 -Patient Centered Care- The transitional care program will support Patient Centered Healthcare by ensuring the needs of the patient are prioritized in the transition from hospital to home. This will be noted by the improvement in patient satisfaction scores and outcomes.

Relationship to Other Performing Providers’ Projects in the RHP:

Two CHRISTUS Santa Rosa hospitals in our region will be focusing on Implementing / expanding Transitional Care. GRMC will reach out to these facilities to establish a collaborative support network. In fact we have identified milestone which will require face to face collaboration with another facility. This metric is: **Milestone 4** [P-12-Participate in face-to-face learning at least twice per year with other providers in the RHP to promote collaborative learning around similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each provider should publicly commit to implementing these improvements.]

Plan for Learning Collaborative:

GRMC and RHP 6 are committed to transforming health care in our region and throughout the service area. University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives.
GRMC will propose projects and provide feedback throughout the development of the RHP Plan which will supports and reinforce related projects and interventions within the RHP Plan.
Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
Identify participants
Establish Learning Collaborative goals
Develop a calendar of regular meetings, site visits, and/or conference calls
Develop a plan to communicate ideas, data, and successes across the region and state
Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices

Adopt metrics to measure success

University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaboratives to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.

**Project Valuation:**

Project 2.12.2- Implement/Expand a Care Transitions was assigned high value through consideration of the following criteria:

- Achieve Waiver Goals: The project will address triple aim, further develop and maintain a coordinated care delivery system, improve outcomes while containing costs, and improve the healthcare model which serves uninsured, Medicaid, and low income residents of the GRMC service area.
- Address Community Need-The project will address multiple community needs with high impact results.
- Project Scope-The project will touch numerous patients whose healthcare can be improved through the tenets designed into the program. As such, multifaceted benefits will be recognized to include but not limited to: cost savings, patient centered care, improved quality of life, and reduction in PPA and PPR.
<table>
<thead>
<tr>
<th>138411709.2.1</th>
<th>2.12.2</th>
<th>N/A</th>
<th>2.12.2 Implement/Expand Care Transitions Program</th>
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<td><strong>TPI - 138411709</strong></td>
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<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>138411709.3.2</strong></td>
<td><strong>3.IT-3.1</strong></td>
<td><strong>All Cause Unplanned 30-day Readmission rate for Patients 18 Years and Older</strong></td>
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<td><strong>Year 2</strong> <em>(10/1/2012 – 9/30/2013)</em></td>
<td><strong>Year 3</strong> <em>(10/1/2013 – 9/30/2014)</em></td>
<td><strong>Year 4</strong> <em>(10/1/2014 – 9/30/2015)</em></td>
<td><strong>Year 5</strong> <em>(10/1/2015 – 9/30/2016)</em></td>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>[P-2]: Implement standardized care transition processes</td>
<td>[P-5]: Using a validated risk assessment tool, create a patient identification system.</td>
<td>[P-6]: Patient stratification system</td>
<td>[P-12]: Participate in face-to-face learning at least twice per year with other providers in the RHP to promote collaborative learning around similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each provider should publicly commit to implementing these improvements.</td>
</tr>
<tr>
<td>Metric 1 [P-2.1]: Care Transition processes</td>
<td>Metric 2 [P-5.1]: Patient stratification system</td>
<td>Baseline/Goal: 80% of patients referred to transitional care program will have an evidence based risk assessment tool completed.</td>
<td>Metric 4 [Metric – P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: meet twice a year with RHP cohorts.</td>
</tr>
<tr>
<td>Baseline/Goal: submission of protocols Data Source: Policies and procedures of care transitions program materials</td>
<td>Data Source: Submission of risk assessment tool [LACE] and patient stratification report description and description of provider utilization of report findings. Rationale/Evidence: This process is designed to identify patients requiring care management and to accommodate a quicker allocation of resources to those patients with high-risk care needs.</td>
<td>Data Source: Submission of risk assessment tool [LACE] and patient stratification report description and description of provider utilization of report findings. Rationale/Evidence: This process is designed to identify patients requiring care management and to accommodate a quicker allocation of resources to those patients with high-risk care needs.</td>
<td>Data Source: Submission of risk assessment tool [LACE] and patient stratification report description and description of provider utilization of report findings. Rationale/Evidence: This process is designed to identify patients requiring care management and to accommodate a quicker allocation of resources to those patients with high-risk care needs.</td>
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<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $ 1,159,045</td>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong></td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $422,711</td>
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<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 6</strong></td>
<td><strong>Milestone 7</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $ 1,047,587</td>
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<tr>
<td>[I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic</td>
<td>[I-11]: Improve the Percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by 35% rate increase from the year 4 patients served, estimated to be 263. Metric 7 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence based interventions per approved clinical protocols and guidelines. Goal: Numerator- Number of patients that receive all recommended education, care and services as dictated by the approved evidence based care guidelines. Denominator- Number of patients discharged or eligible for care transitions services. Data Source: Registry or EHR report/Analysis</td>
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<td>Milestone 2</td>
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**Milestone 3**  
[I-11]: Improve the Percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by 20% rate increase from the estimated year 2 baseline of 175.

**Metric 3** [I-11.1]: Number over time of those patients in target population receiving standardized, evidence based interventions per approved clinical protocols and guidelines.

Goal: Numerator - Number of patients that receive all recommended education, care and services as dictated by the approved evidence based care guidelines.  
Denominator - Number of patients discharged or eligible for care transitions services.

Data Source: Registry or EHR report/Analysis

**Metric 5**: [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. Number over time of those patients in target population receiving standardized, evidence based interventions per approved clinical protocols and guidelines.

Goal: List by frequency of most prevalent chronic conditions, patient factor or socioeconomic factors in patient panel resulting in highest re-admission rates.

Data Source: Registry or EHR report/Analysis

Rationale/Evidence: Assessing the most prevalent conditions and factors that lead to re-admissions will allow the provider to address the needs of the patient population more effectively.

**Milestone 5** Estimated Incentive Payment: $422,711

**Milestone 6**  
[I-11]: Improve the Percentage of patients in defined population receiving standardized care according to factors that are common causes of avoidable readmissions.

**Goal:** List by frequency of most prevalent chronic conditions, patient factor or socioeconomic factors in patient panel resulting in highest re-admission rates.

Data Source: Registry or EHR report/Analysis

Rationale/Evidence: Assessing the most prevalent conditions and factors that lead to re-admissions will allow the provider to address the needs of the patient population more effectively.
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<thead>
<tr>
<th>Year 2 Estimated Milestone</th>
<th>Year 3 Estimated Milestone</th>
<th>Year 4 Estimated Milestone Bundle Amount</th>
<th>Year 5 Estimated Milestone Bundle Amount</th>
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<td>$1,268,132</td>
<td>$1,047,587</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,739,220**
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title:</th>
<th>2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>138411709.2.2 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Guadalupe Regional Medical Center</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>138411709</td>
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</tbody>
</table>

### Project Summary:

**Provider Description:** Guadalupe Regional Medical Center is a 125-bed hospital in Seguin, Texas serving Guadalupe and the surrounding counties; serving a population of approximately 100,000.

**Intervention(s):** The Patient Navigation project will identify patients with high utilization of ED services, and assist to match resources; such as physicians, clinics, teaching, behavioral health and prescription assistance. Through decreasing overutilization of chronic issues, the ED will be freed up to care for patients with acute illness and injury.

**Need for the project:** Currently the ED is over utilized by patients with chronic medical conditions that could be stabilized through education and ongoing medical care through a clinic or PCP, as well as those patients that frequently utilize the ED for non-emergent care.

**Target population:** The target populations are those patients with high frequency use of the ED for chronic medical conditions, non-emergent medical needs and behavioral health.

**Category 1 or 2 expected patient benefits:** In calendar year 2012, the Emergency Department saw 36,433 patients of which 30% were classified as either Medicaid or Indigent. Also out of those 36,433 patients, approximately 35% of those visits were classified as non-urgent. There were also approximately 9,500 patient encounters that didn’t have a primary care physician identified. This project expects to enroll 50% of identified patients in the Patient Navigation System and increase the number of referrals to a PCP for patients without a PCP by 50%.

**Category 3 outcomes:** IT-9.2 - The focus is on Reducing Emergency Department visits for target conditions, behavioral health/substance abuse. By implementing the Patient Navigation System, GRMC ED would like to decrease the unnecessary ED visits for behavioral health/substance abuse by 3% by year 5. This will provide patients with behavioral health/substance abuse issues the resources needed to effectively manage their conditions.

### Project Description:

Guadalupe Regional Medical Center seeks to establish a patient navigation system to assist high utilizers of the ED to receive coordinated, timely and appropriate healthcare services.

Development of the Navigation Program will identify high utilizers of ED services. A multidisciplinary care team will be developed for patients enrolled in the program, care plans will be developed and each patient will be assigned a patient navigator to assist patient in obtaining PCP, behavioral healthcare, specialty care as needed and community resources. The role of the multidisciplinary team is to review potential enrollees, review needs and develop and implement care plans. The team is made up ER staff & Medical Director, Case Management, and a Licensed Clinical Social Worker. The goal of this project is to utilize community health workers and case managers to provide enhanced social support and culturally competent care to
vulnerable and/or high-risk patients, to divert non-urgent care from the Emergency Department to site-appropriate locations. The program would also meet regional goals, along with the RHP and CMS’s triple aims to improve care for individuals; improve health for the population; and lower costs through improvements.

The current challenges are high utilizers are given referrals for community resources and follow up care; many do not follow up with the referral and continue to receive care through the ED. GRMC believes that a patient navigation system will allow for timelier ED services for emergency situations, reduce costs and decrease the amount of financial loss due to inappropriate and possibly unfunded ED visits.

The program’s 5-year expected outcome is to increase patient enrollment in patient navigator system by 50% of identified patients of the targeted population, as well as a 50% increase in the number of ED patients referred to a PCP who are documented as not having a PCP. The program also hopes to have a reduction in unnecessary ED use related to behavioral health/substance abuse by 3% of baseline by DY5 as referenced in the Category 3 Outcome Measure.

**Starting Point/Baseline:**

In August 2012, the preliminary workgroup that included ER staff, Case Management, and Social Services met to discuss ideas geared towards decreasing unnecessary ER visits by identifying high utilizers of the ED.

Through Meditech reports, chart review, and as well as staff education of navigation project, patients are being identified as potential enrollees in the navigation system.

To date a policy and procedure has been drafted to identify and enroll patients. As of October 2012, 4 patients have been identified as frequent utilizers of emergency services for chronic pain management. 1 patient has been enrolled in the program with an identified care plan in place.

**Rationale:**

Guadalupe County has a largely rural service area with an established population possessing morbidities and co-morbidities which have significant potential for causing unnecessary utilization of the ED. Patient navigators will help patients and their families navigate the healthcare system and the obstacles that it entails. Services provided by the ED patient navigators will include: facilitating more appropriate care options, coordinating care among providers, assisting with obtaining follow up care and maintaining relationships with providers. Community health care workers and the ER Case Manager will have close ties to the community and serve as a liaison between the community and the healthcare system. They will also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Patient navigators will be: compassionate, sensitive, and culturally attuned to the people; knowledgeable about the environment and healthcare system, and connected with critical decision makers inside the system.

**Project Components:**

Through the ED Patient Navigation Program, we propose to meet all required project components.

a. Identify frequent ED users and use navigators as part of a preventable ED reduction
program. Train health care navigators in cultural competency. Patients using the emergency department for primary care services, behavioral healthcare services, patients without a designated PCP or medical home, and patients with social or economic barriers to accessing primary care will be offered navigation services. Patient Navigators will create care plans that will be associated with the patients’ medical record by medical record number. These notes will include sections on reason for services, assessment, subsequent referrals and follow-up activities. Patient navigators will review the care plan with the patient and provide a copy. All of our navigators will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, chronic disease management, and recognizing behavioral healthcare crisis.

b. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. We plan to hire Patient Navigators with a background in community health, social services, mental health, or public health with experience providing direct care to disadvantaged populations. Ideally these individuals will be bilingual, from our community, and experienced in identifying community resources.

c. Connect patients to primary and preventive care

d. Increase access to care management and/or chronic care management – We will have regular contact with area primary care providers and behavioral health for care management services, preventive care, and other educational and social services. Navigators will be available to meet with providers to answer any specific questions.

e. Conduct quality improvement for project using methods such as rapid cycle improvement – The navigation workgroup will design a reporting template for the Patient Navigator notes. We will create a data registry for enrolled patients to facilitate follow-up and effectiveness analysis. Reports will be run weekly by the program and shared monthly with ED staff and participating primary care providers. We will hold bi-weekly meetings with navigation workgroup and with ED providers quarterly to discuss opportunities for program improvement and expansion.

GRMC will develop and expand a patient navigation system which will address Unique Community Needs:

- **CN.3** – Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsured people and health care provider shortages.
- **CN.4** – There is a shortage of high quality mental and behavioral health services that are integrated with physical healthcare services.

Currently, a patient navigation program does not exist to guide and connect patients to more appropriate care for the non-urgent medical needs.
**Related Category 3 Outcome Measure(s):**

GRMC has chosen the stand-alone Category 3 Outcome Measure IT-9.2: ED Appropriate Utilization. We are going to focus on reducing Emergency Department visits for the target condition of Behavioral Health/Substance Abuse. The ED sees many patients who utilize the ED for non-emergent conditions such as medication refills, behavioral health problems, lack of resources relating to substance abuse, etc. The hope is that by implementing the Patient Navigation system, along with the other projects (1.1.2 and 2.12) being proposed by GRMC, the amount of unnecessary visits to the ED relating to behavioral health/substance abuse will decrease.

- **Numerator:** Number of patients enrolled in the navigator program who have had an ED visit or an inpatient admission
- **Denominator:** Total number of patients enrolled in the navigator program

A study completed by the Association for Community Affiliated Plans in April 2007, at least 1/3 of all ED visits are avoidable, meaning non urgent, and therefore treatable in primary care centers. Over 18 billion dollars are wasted annually on avoidable ED visits. In addition, it is shown that emergency departments serving higher proportions of patients that are Medicaid eligible or uninsured have 25% more non urgent cases presenting.

In addition, Guadalupe County is federally designated as a mental health professional shortage area. According to a study completed by Salinski and Loftis (2007), Mental health related ER visits increased 75% from 1992 to 2003. An additional example provided by MSNBC in 2009, reported in Austin Texas showed that only 9 patients accounted for 2700 ER visits in a one year period. Agency for Healthcare Research and Quality also completed a report in 2010 showing that mental disorders/substance abuse related visits equal 1 of every 8 emergency department cases. Not only is this situation traumatic for the psychiatric patient, but it also takes scarce resources away from the patient with medical emergencies.

According to the Texas Department of State health services, 46% of all ER visits have a behavioral health issues as a basic or contributing factor.

**Relationship to other Projects:**

This Patient Navigator Project will work in close conjunction to the two other projects being proposed by GRMC. The first project is 1.1.2; expanding care with a free clinic that offers services to the uninsured population in Seguin, Texas and the surrounding areas. Through access to this clinic, patients who normally may have sought care in the ED for non-urgent conditions have another option to seek care. We will be working closely with the clinic for follow-up care.

The second project is 2.12; Implementing and Expanding a Transitional Care program. This program will be of great assistance to the population of patients with chronic illness who seek their primary care in the ED. By communicating with the Transitional Care program, the needs of these patients, there may be other resources that can be offered besides coming to the ED.

In addition, GRMC will also collaborate with Bluebonnet Trails Community Services to assist in providing mental health and substance abuse services. Through navigation services, GRMC with the help of Bluebonnet Trails Community Services will target persons with chronic mental
illnesses who are frequent users of the Emergency Department due to behavioral health disorders.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Unknown at this time.

**Plan for Learning Collaborative:**
GRMC and RHP 6 are committed to transforming health care in our region and throughout the service area. University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives. GRMC will propose projects and provide feedback throughout the development of the RHP Plan which will support and reinforce related projects and interventions within the RHP Plan.

Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
- Identify participants
- Establish learning collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaboratives to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.

**Project Valuation:**
Project 2.9.1 Establish/Expand a Patient Care Navigation Program was assigned high value through consideration of the following criteria:
- Achieve Waiver Goals - The project will address triple aim, further develop and maintain a coordinated care delivery system, improve outcomes while containing costs, and improve the healthcare model which serves uninsured, Medicaid, and low income residents of the GRMC Service Area
- Address Community Need – The project will address multiple community needs with high impact on results, acting as a liaison between the under insured/uninsured patient and behavioral and medical healthcare.
- Project Scope – The project will touch numerous patients whose healthcare can be improved through access to appropriate resources.
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<tr>
<th>138411709.2.2 PASS 2</th>
<th>2.9.1</th>
<th>2.9.1 A-E</th>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**
[P-1]: Conduct a needs assessment to identify the patient population (s) to be targeted with the Patient Navigator Program

**Metric 1** Metric P-1.1: Provide a report identifying the following:
- Targeted patient population characteristics i.e. frequent ED utilization
- Gaps in services and service needs
- How program will identify, triage and manage target population (i.e. policies/procedures, navigation protocols, flowcharts)
- Ideal number of patients targeted for enrollment in the patient navigation

**Milestone 2**
[P-3]: Provide care management/navigation services to targeted patients

**Metric 1** P-3.1: Increase the number or percent of targeted patients enrolled in the program-goal is to increase enrollment by 20% of identified patients

- **Numerator:** Number of targeted patients enrolled in the program
- **Denominator:** Total number of targeted patients identified

Data Source: Meditech reports and chart reviews

**Milestone 2 Estimated Incentive Payment:** $ 328,381

**Milestone 3**
[I-6]: Increase number of PCP

**Milestone 4**
[P-3]: Provide care management/navigation services to targeted patients

**Metric 1** P-3.1: Increase the number or percent of targeted patients enrolled in the program-goal is to increase enrollment by 35% of identified patients

- **Numerator:** Number of targeted patients enrolled in the program
- **Denominator:** Total number of targeted patients identified

Data Source: Meditech reports and chart reviews

**Milestone 4 Estimated Incentive Payment:** $ 330,504

**Milestone 5**
[I-6]: Increase number of PCP

**Milestone 6**
[P-3]: Provide care management/navigation services to targeted patients

**Metric 1** P-3.1: Increase the number or percent of targeted patients enrolled in the program-goal is to increase enrollment by 50% of identified patients

- **Numerator:** Number of targeted patients enrolled in the program
- **Denominator:** Total number of targeted patients identified

Data Source: Meditech reports and chart reviews

**Milestone 6 Estimated Incentive Payment:** $ 272,694

**Milestone 7**
[I-6]: Increase number of PCP

653 ★ RHP 6 Plan ★ March 8, 2013 Guadalupe Regional Medical Center
program

- Number of patient navigators needed to be hired
- Available site, state, county, and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients

Data Source: Program documentation, E.H.R., claims, needs assessment survey

Rationale: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.

Milestone 1 Estimated Incentive Payment $ 601,090

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<th>referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 10%. Based on 2012 estimates of 9500 patients without a PCP, this would be approximately 950 patients. Metric I-6.3-Percents of patients without a primary care provider in the ED</th>
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<tbody>
<tr>
<td>Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP</td>
</tr>
<tr>
<td>Denominator: ED patients without a PCP documented in their medical record.</td>
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</table>

Data source: Administrative data on patient encounters and referral records from Patient Navigator Program

Rationale: Patient care navigation has been established as best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatients and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost, and quality

referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 25%. Based on 2012 estimates of 9500 patients without a PCP, this would be approximately 2375 patients. Metric I-6.3-Percents of patients without a primary care provider in the ED |

Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP |

Denominator: ED patients without a PCP documented in their medical record. |

Data source: Administrative data on patient encounters and referral records from Patient Navigator Program

Rationale: Patient care navigation has been established as best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatients and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost, and quality

referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 50%. Based on 2012 estimates of 9500 patients without a PCP, this would be approximately 4750 patients. Metric I-6.3-Percents of patients without a primary care provider in the ED |

Numerator: Number of ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP |

Denominator: ED patients without a PCP documented in their medical record. |

Data source: Administrative data on patient encounters and referral records from Patient Navigator Program

Rationale: Patient care navigation has been established as best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatients and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost, and quality
<table>
<thead>
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<th>Year 2 Estimated Milestone Bundle Amount: $ 601,090</th>
<th>Year 3 Estimated Milestone Bundle Amount: $ 656,762</th>
<th>Year 4 Estimated Milestone Bundle Amount: $ 661,008</th>
<th>Year 5 Estimated Milestone Bundle Amount: $ 545,387</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,464,247**
Identifying Project and Provider Information:

Title: 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Health Screening and Education for the Uninsured
Unique RHP ID#: 136430906.2.1 – PASS 1
Performing Provider: Hill Country Memorial Hospital
Performing Provider TPI: 136430906

Project Summary:

Provider Description: Hill Country Memorial Hospital is an 88-bed medical center serving eight counties and a population of 140,000.

Intervention(s): This project will provide comprehensive health screening and wellness education for at least 500 uninsured (targeting Medicaid and Indigent individuals) employed residents of Hill Country Memorial Hospital’s service area by partnering with local businesses who are not able to offer insurance to their employees or whose employees are unable to afford the insurance offered due to cost and their low incomes.

Need for the project: All but one of the counties in Hill Country Memorial Hospital’s service area have a higher uninsured rate than the already-high Texas state rate. Gillespie County, in which the hospital is located, is home to more than 4500 uninsured individuals (27.5% of county residents), and the hospital’s 8 county service area has almost 30,000 without health insurance. The majority of the businesses in the county and region are small, with fewer than 50 employees, and many are farms. Of small businesses in Texas, only 37% offer health insurance to their employees, and this region is no different.

Target population: The uninsured employees (specifically targeting indigent and Medicaid-funded populations) of local businesses which are unable to offer health insurance as a benefit to their employees. We anticipate at least 500 of these individuals will be served.

Category 1 or 2 expected patient benefits:
At least 500 uninsured individuals (specifically targeting indigent and Medicaid-funded populations) have been screened for eligibility for the following screenings, and then received those as appropriate per USPSTF recommendations: Colorectal Cancer Screening, Screening and Brief Intervention for Alcohol Abuse, Cervical Cancer Screening, Screening for Diabetes, Blood pressure Screening, Screening for Lipid Disorders, HIV Screening, Breast Cancer Screening, BMI screening for Obesity, as well as Mobility/Strength Screening, Health Risk Assessment and recommendations, Customized healthy lifestyle consult, and Customized Community Resources Consult. Beyond this, patients may receive additional screenings as identified through ongoing program evaluation and target population needs assessments.

Category 3 outcomes:
- Screening for cervical cancer will be provided for 100% of the eligible target population of 500 uninsured individuals.
- Screening for colorectal cancer will be provided for 100% of the eligible target population of 500 uninsured individuals.
Screening for high blood pressure will be provided for 100% of the eligible target population of 500 uninsured individuals (specifically targeting indigent and Medicaid-funded populations).

**Project Description:**

**Goal:** Provide health screening and wellness education for underserved residents of Hill Country Memorial Hospital’s service area.

**Challenges**

Hill Country Memorial Hospital’s service area includes 8 counties, all but one of which have a higher uninsured rate than the already-high Texas state rate. Gillespie County, in which the hospital is located, is home to more than 4500 uninsured individuals (27.5% of county residents), and the hospital’s 8 county service area has almost 30,000 without health insurance. The majority of the businesses in the county and region are small, with fewer than 50 employees, and many are farms. Of small businesses in Texas, only 37% offer health insurance to their employees, and this region is no different.

Even if insurance becomes available to many more individuals in the years ahead, many in these underserved and remote counties will not have access to a local healthcare provider. It is already a major challenge for the community physicians to provide needed screening services to the currently-insured population. There are simply not enough licensed independent practitioners in this more-rural region of the state.

Preventive care and screenings are low on the priority list of many of these individuals, who are faced with more pressing current concerns and who do not typically seek medical care except in major illness.

**Addressing the Challenges**

Hill Country Memorial has begun to pilot a wellness education and screening program as an additional service of the hospital, available to businesses wishing to offer their insured employees an employment “perk”. The vision for the DSRIP project is to develop a companion program that is specifically targeted to the uninsured employed. This program would focus on the unique health needs and concerns of those who may have not had regular health care in many years. Screening services and wellness education would be offered by Hill Country Memorial Hospital staff members and closely linked to community resources through a strong case management component. It will be important to insure that this vulnerable population has ongoing access to any needed healthcare identified through the screening process. The goal of the program will be to provide United States Preventive Services Task Force-recommended screening services along with wellness education and support to employees of local businesses that have uninsured employees, as well as their spouses or partners. The program would be offered at a very low cost to the business owner to offer as a bonus or incentive to employees and their partners at no cost to them. The goal of the program is to start at least 500 individuals on the program by the end of the fifth demonstration year of the project.

This project targets low income, underserved and uninsured individuals who would not otherwise have access to preventive health care. It supports local businesses who would like to provide opportunities for their employees to receive healthcare services, but cannot provide health insurance options at all or those that are affordable to their low-income employees. Partnering with the hospital and DSRIP program will allow them to offer health screening and wellness counseling services to their employees and their families, and support them in connecting to ongoing care as needed in the community. It also encourages individuals who may not value preventive care to strongly consider it since it is being promoted by their employer and colleagues.
The five year expected outcome for our community is that at least 500 uninsured individuals have been screened for eligibility for the following screenings, and then received those as appropriate per USTPSTF recommendations:

- Colorectal Cancer Screening
- Screening and Brief Intervention for Alcohol Abuse
- Cervical Cancer Screening
- Screening for Diabetes
- Blood pressure Screening
- Screening for Lipid Disorders
- HIV Screening
- Breast Cancer Screening
- BMI screening for Obesity
- Additional screenings and services
  - Mobility/Strength Screening
  - Health Risk Assessment and recommendations
  - Customized healthy lifestyle consult
  - Customized Community Resources Consult

While the first year will be at a zero or nominal cost to the employer, businesses will be offered the opportunity to continue in the program at a low cost, providing needed screenings and wellness education to their employees annually.

Regional Goals

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

This project directly impacts all of the region 6 goals. First, the provision of needed screening services to the key target population in the region is being provided at a relatively low cost, given that much of the needed resources already exist within the hospital. Expanding staff hours, increasing use of existing space and equipment, and building on patient records systems that already exist allow for economies of scale. The services will be provided by highly-trained professionals with a reputation for quality and in a patient-centered way that also supports local businesses. Many of the target population will not have previously accessed the local resources for receiving healthcare in the safety net or for finding funding for their care. Care coordination will be a key service to get these individuals started in a patient centered medical home.

Starting Point/Baseline:

While Hill Country Memorial Hospital’s companion program for the insured employed of large businesses has had a number of patients complete the program, this program targeted to the uninsured population has not yet been started. Additional information acquired through outreach and implementation-planning efforts will be key to designing a program that meets this population’s unique and ongoing needs. No care providers have yet been trained as the program is still in development.
Rationale:

Reasons for Selecting the Project
The strength and productivity of our workforce and student population depends on the good health of all residents. Unfortunately, many have jobs where health insurance is not offered, and many Texas industries are reducing health care coverage. Texas has a large and diverse population of uninsured and underinsured individuals, 80 percent of whom work or have a working family member. Under the Affordable Care Act, many more people will have access to affordable coverage in 2014. However, due to gaps in programs and the supreme court ruling that a Medicaid expansion is not mandatory, a sizeable population of Texans will continue to be uninsured. The uninsured are less likely to receive adequate care and often when they do, it comes later, with serious consequences such as increased mortality and lower quality of life. Furthermore, the uninsured and underinsured are less likely to receive the preventive care they need.

In addition, small businesses with less than 50 employees constitute 73 percent of all businesses in Texas. Of these small businesses, only 37 percent offer insurance. This is significantly below the 45 percent national average. Furthermore, only 35 percent of employees in small businesses that offered insurance actually enrolled, in comparison with 63 percent of employees in large businesses (IOM, 2003). This could be a result of small businesses offering less appealing or more expensive packages.

The uninsured are more likely to be hospitalized for problems that could have been prevented had they received appropriate and timely outpatient care. In the end, the cost of not seeking preventive care to individuals, employers, and communities, is staggering. Uncompensated care provided by Texas hospitals increased to more than $7.7 billion in 2003 from $3 billion in 1993 (Center for Health Statistics, 2004).

Overall, the uninsured receive less preventive care, are diagnosed at more advanced stages of disease, and once diagnosed, receive less therapeutic care than do the insured. Thus, lack of adequate insurance leads to premature death. The case of cancer, the second leading cause of death in Texas, is illustrative of this point. Individuals who are poor, lack health insurance, or otherwise have inadequate access to quality cancer treatment experience higher cancer incidence, higher mortality rates and poorer survival rates (IOM, 2002).

Unique Community Need
This project addresses two key RHP community needs. The first is CN.2: “A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.” The project will very directly affect the health disparity in prevention efforts, specifically by providing screening for chronic diseases, including cardiovascular disease, cancer, and diabetes. If these diseases are caught in the pre-disease or early stages, interventions and outcomes are much less costly to the individual and community. The second key RHP need that this project addresses is CN.3: “Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.” The project is specifically targeted to populations who are uninsured and takes place within the context of a region that has a provider shortage in uninsured and publicly funded patient primary care. Because there simply are not other options at the moment, this program will be an important “first step” into preventive care and wellness education, followed by navigation to sources of care for the long-term.

New Initiative for the Performing Provider
While Hill Country Memorial Hospital’s companion program for the insured employed of large businesses has had a number of patients complete the program, this program targeted to the uninsured population has not yet been started. Additional information acquired through outreach and implementation-planning efforts will be key to designing a program that meets this population’s unique and ongoing needs.

The Quality Improvement process of the project will include a thorough evaluation of program, implementation, and outreach effectiveness to take place in DY4. In DY5, course corrections indicated by this evaluation (the “check” stage of the PDCA cycle) will be implemented. In DY5, expansion plans and long-term sustainability of the project will be finalized.

References:
Code Red 2012 (http://www.coderedtexas.org/)
United States Preventive Services Task Force Screening Recommendations
   (http://www.uspreventiveservicestaskforce.org/uspstestopics.htm#AZ)
   (http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm#Insurance)

Related Category 3 Outcome Measure(s):
Projects 136430906.3.1, 136430906.3.2, and 136430906.3.3 have as their goal the completion of 3 specific preventive care screenings for the target population, uninsured employees of Gillespie County businesses. These screenings are for cervical cancer, colorectal cancer, and high blood pressure, respectively. These goals are directly related to the work of the program, as the plan is to provide these three screening services, among others, to as many of the uninsured target population as are eligible for them per USPSTF guidelines. We believe that the most effective means to do this within our community is to partner with local businesses, strengthening their employee health. In 2010, researchers reviewed 36 studies of corporate wellness programs. They calculated that employers saved an average of $6 for every $1 spent, including $3.27 saved in medical costs and an additional $2.73 gained because of reduced absenteeism. An earlier analysis of 56 studies found that health promotion programs in organizations of all sizes reduced sick leave, health plan costs, and worker compensation and disability costs by about 25 percent. A major meta-synthesis of studies on workplace screening and wellness programs found even greater impact in many cases. Eight studies evaluated the impact of wellness programs on healthcare cost and all but 1 study found significant decreases. Effects included a reduction in direct medical cost between $176 and $1539 per participant per year. Four studies evaluated absenteeism costs, as defined by the estimated cost of missed workdays. Each of these studies found significant effects, expressed as an ROI of $15.60 per dollar spent, $1350 saved per employee in short-term disability costs, 0.1% point risk reduction in illness days, and $180 saved per participant per year.
Since the individuals in our program’s target population are not insured, then we can imagine that the costs attributed to medical cost savings here would be absorbed by the community while
the increased employee productivity would benefit the company directly. This means, that for the 500 individuals involved in the program, we could expect a reduction in healthcare costs to the community of up to $1,077,300 per year of the program. In addition, the savings in prevented lost productivity would equal up to 5% of employee payroll, or around $1,125,000 for 500 employees. Also, these studies have shown that the program has positive impact beyond immediate medical cost savings. Long-term benefits include decreased severity of or prevention of chronic disease, improvement in exercise, healthy diet, and physiologic markers and a decrease in smoking and alcohol use. In the long-run, a single hospitalization for cancer, diabetes, hypercholesteremia, or any of the other conditions being tested for would cost about $10,000 (http://www.beckershospitalreview.com/lists/average-cost-per-inpatient-day-across-50-states-in-2010.html). By identifying these conditions early, at least 25 such hospitalizations are likely to be prevented in the years after the program, providing at a minimum $250,000 in additional community benefits.

References:

Relationship to other Projects:
This project is also related to Category 4 population-focused measures for Potentially Preventable Admissions, RD-2. It is very likely that, in the short-term and the long-term, uninsured patients with ambulatory care sensitive conditions will be less frequent visitors to both the emergency room and inpatient units. If these conditions are caught early in the disease process, then care can be received in an appropriate setting. If the conditions are not screened for and noted early, patients are more likely to end up in the emergency or inpatient setting in either more critical condition or because they have no medical home.

Relationship to Other Performing Providers’ Projects in the RHP:

Plan for Learning Collaborative:
Lessons learned will be shared in the RHP Learning Collaborative and in conferences and other settings which will be set up following completion of the RHP Plan. They will be working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following: Identify participants, establish Learning Collaborative goals, develop a calendar of regular meetings, site visits, and/or conference calls, develop a plan to communicate ideas, data, and successes across the region and state, organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices, and adopt metrics to measure success.

A website will be available to the Learning Collaboratives to network and share ideas.
challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State. Hill Country Memorial Hospital anticipates significant involvement in contributing to and learning from our learning collaborative. Lessons learned will be shared along the way, allowing others to make course corrections noted through the experience of other performing providers.

Project Valuation:

This Category 2 project is valued at $2,625,518 for demonstration years 2-5. It is perfectly in line with the Triple Aim, providing high-quality screening and preventive services as well as rich wellness support for uninsured residents of our community. The program is cost effective due to the ability to utilize many existing hospital services and facilities to provide this important service. In addition, utilizing individuals working at the top of their license will ensure that patients are receiving best care at lowest possible cost. Within only 3 years of implementation, it is our goal to provide a very comprehensive health screening to 500 individuals, or 16% of the uninsured population in our immediate community. Once they have been screened and educated, we will also be ensuring that they are connected to ongoing sources of care, helping our uninsured neighbors to navigate their way through the local health system and any funding opportunities for which they may be eligible. Because the program is ongoing, the 500 individuals will have the opportunity to come back year after year if the business finds that it is useful for their employees. This will multiply the impact of the program.

There is a wealth of literature supporting high value preventive care, and increased focus on preventive care has been a major part of health reform discussions. The Partnership for Prevention, who published the paper, “Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost,” did a cost-benefit analysis of 20 preventive health care services and “estimated how much in health care costs would have been saved in a given year if 90 percent of the population had used those services. For 2006, the year selected, the savings were estimated at $3.7 billion” (Health Affairs, 2010). Workplace wellness programs have been shown to be so successful that the Centers for Disease Control has commissioned an entire program to provide basic toolkits for businesses interested in providing this key service to employees.

Though the impact of the program will be on the community as a whole through improved wellness, early disease intervention, and decreased healthcare costs, employers participating in the wellness intervention will likely benefit as well.

The program will require a number of human resources, including physician, nurse practitioner, navigator/health educator, outreach, and administrative. In addition, existing hospital resources and equipment, such as mammography equipment, building space, lab supplies and staff will be leveraged. Outreach will require significant time and cost as the target population will need to be reached in a variety of ways.

References:
Health Affairs, 29(2), 304-311. (http://content.healthaffairs.org/content/29/2/304.abstract)
of the Impact of Worksite Wellness Programs. American Journal Of Managed Care, 18(2), e68-81.
Code Red 2012 (http://www.coderedtexas.org/)
United States Preventive Services Task Force Screening Recommendations
(http://www.uspreventiveservicestaskforce.org/uspstopics.htm#AZ)
(http://smpbffl.dsd.census.gov/TheDataWeb_HotReport/servlet/HotReportEngineServlet?reportid=76bcc36ed9471da36142c866fe686b8a&emailname=saeb@census.gov&filename=sahie09_county.html)
U.S. Department of Health and Human Services. Overview of the Uninsured in the United States:
(http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm#Insurance)
<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<td>PASS 1</td>
<td>2.7.1</td>
<td>N/A</td>
<td>2.7.1 IMPLEMENT INNOVATIVE EVIDENCE BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS: HEALTH SCREENING AND EDUCATION FOR THE UNINSURED</td>
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<td>Hill Country Memorial Hospital</td>
<td>TPI - 136430906</td>
<td>Cervical Cancer Screening (HEDIS 2012)</td>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
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<td>Outcome Measure(s):</td>
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<td>Milestone 1</td>
<td>Development of innovative evidence-based project for targeted population.</td>
<td>[P-1] Development of innovative evidence-based project for targeted population.</td>
<td>[P-2]: Implement evidence-based innovative project for targeted population</td>
<td>[P-4]: Execution of evaluation process for project innovation.</td>
<td>[P-4]: Execution of evaluation process for project innovation.</td>
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<td>Baseline: 0 businesses enrolled</td>
<td>Goal: Goal is implementation of the program by at least one business.</td>
<td>Goal: Complete evaluation of intervention.</td>
<td>Goal: Implement and evaluate changes suggested by previous year’s evaluation process. Document and share lessons learned.</td>
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<td>Data Source: Performing Provider evidence of innovational plan</td>
<td>Data Source: Performing Provider Memorandum of Understanding with participating business.</td>
<td>Data Source: Performing Provider Memorandum of Understanding with participating business.</td>
<td>Data Source: Documentation of evaluation process, findings, and innovations and changes suggested by the data.</td>
<td>Data Source: Documentation of implementation and evaluation process.</td>
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<td>Milestone 3</td>
<td>Milestone 5</td>
<td>Milestone 7</td>
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<td>[I-5]: 100 patients in defined population receiving innovative intervention consistent with evidence-based model.</td>
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<td>Metric 1 [I-5.1]: 100 individuals have received screening and wellness intervention</td>
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<td>Baseline: 0 patients served in DY2</td>
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<td>Goal: 100 patients by end of DY3</td>
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<td>[I-5]: 200 additional patients in defined population receiving innovative intervention consistent with evidence-based model.</td>
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<td>Metric 1 [I-5.1]: At least 300 individuals have received screening and wellness intervention since start of program.</td>
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<td>Baseline: 0 patients served in DY2</td>
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<td>Goal: 300 or more patients served by end of DY4.</td>
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<tr>
<td>Metric 1 [I-5.1]: At least 500 individuals have received screening and wellness intervention since start of program.</td>
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<td>Baseline: 0 patients served in DY2</td>
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<tr>
<td>Goal: 500 or more patients served by end of DY5.</td>
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<td>Milestone 7 Estimated Incentive Payment: $290,185</td>
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| Year 2 Estimated Milestone Bundle Amount: $642,109 |
| Year 3 Estimated Milestone Bundle Amount: $700,506 |
| Year 4 Estimated Milestone Bundle Amount: $702,542 |
| Year 5 Estimated Milestone Bundle Amount: $580,361 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,625,518**
Identifying Project and Provider Information:

Title: 2.4.2 Redesign to Improve Patient Experience
Unique RHP ID#: TPI 094154402.2.1 – PASS 1
Performing Provider: Methodist Hospital
Performing Provider TPI: 094154402

Project Summary:

Provider Description: Methodist Hospital, 45-0388, includes the campuses of six acute care hospitals: Methodist Hospital, Methodist Children’s Hospital, Methodist Specialty and Transplant Hospital, Northeast Methodist Hospital, Metropolitan Methodist Hospital, and Methodist Texan Hospital. For more than 49 years Methodist has provided high quality care to patients from San Antonio and throughout South Texas.

Intervention(s): This project aims to improve how patients experience the care and the patient's satisfaction with the care provided. One large challenge we face is that positive outcomes in healthcare are dependent not only upon the clinical success of treatment, but also upon a patient's perception of the overall experience, which improves compliance and understanding. This experience is comprised, in part, of communication with the caregivers regarding different aspects of the process, as well as the level of service with respect to clean/quiet environment for healing and a responsive staff aimed at meeting needs in a timely manner. In order to better partner with our patients to round out this overall experience, focus upon patient satisfaction metrics and methods to achieve improvement thereof is necessary.

Need for the project: A review of Methodist Hospital’s patient satisfaction scores and the correlation to quality patient care has shown a need in the community for this project. This project was selected due to the identification of a gap in actual versus desired patient engagement, as positive experiences contribute to positive outcomes. We have a diverse community with specific needs across gender, age, race and religion. Identifying the needs and meeting them in a better fashion will help improve understanding and end results. In fact, the most recent CMS data uploaded in October, 2012 indicates that San Antonio is significantly lower in every category than both the Texas and the U.S. averages. While we considered addressing option 2.4.1 as well, we ultimately decided that it was less appropriate for Methodist Hospital as we feel that would be a step backward. The facilities have already initiated significant efforts toward identifying the need to focus upon patient experience, collecting the data, engaging a vendor, and identifying paths for improvement.

Target population: The project will benefit all patients who have services at Methodist Hospital and submit a patient satisfaction survey. Approximately 30% of the total patients seen at Methodist Hospital are either Medicaid and/or indigent patients and are expected to benefit from this project.

Category 1 or 2 expected patient benefits: This project seeks to improve patient satisfaction scores by 4% by DY 5. The patient experience assessed will allow our patients to actively participate in changing the culture of healthcare in our hospital. With improvements to the patient experience, we anticipate the quality of care and outcomes to improve in alignment with the patient experience. Approximately 7,000 patient satisfaction surveys are completed per year at MHS. MHS will establish a baseline for patient satisfaction sample size during DY 3. It is estimated that the sample size of patient satisfaction surveys will increase by 2% of baseline in DY 4 and 4% of baseline in DY 5. Methodist Hospital estimates that approximately 30% of these patient are indigent and Medicaid patients.

Category 3 outcomes: Our goal is to improve 4% over baseline for Customer
Engagement scores by DY5.

**Project Description:**

This project aims to improve how patients experience the care and the patient's satisfaction with the care provided. We utilize the patient satisfaction survey tools, as well as other internal, more real-time solutions in order to obtain feedback regarding all aspects of the patient experience. These combined sets of metrics will help us direct our dedicated executive to improve patient satisfaction scores by 4% by the end of 5 years. A newly created position will spend the next six months working with our current Coach to learn the skills and mechanisms they utilize to train our staff on customer engagement tactics. At the end of the training period, this person will be dedicated to the system, traveling among all our campuses to coach and train our staff and management toward better patient experiences.

One large challenge we face is that positive outcomes in healthcare are dependent not only upon the clinical success of treatment, but also upon a patient's perception of the overall experience, which improves compliance and understanding. This experience is comprised, in part, of communication with the caregivers regarding different aspects of the process, as well as the level of service with respect to clean/quiet environment for healing and a responsive staff aimed at meeting needs in a timely manner. In order to better partner with our patients to round out this overall experience, focus upon patient satisfaction metrics and methods to achieve improvement thereof is necessary.

Methodist understands that continuous quality improvement is at the heart of this project. Therefore, in the implementation of this project, Methodist will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, Methodist will ensure that all methodologies used will meet or exceed any applicable nationally recognized protocol or quality benchmarks.

This project is aligned with the following Region 6 goal:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways

**Starting Point/Baseline:**

As of December 1, 2011, the MHS system averaged a 68.7 on the internal patient satisfaction metrics. There was no dedicated executive to improve these results.

**Rationale:**

This project was selected due to the identification of a gap in actual versus desired patient engagement. Our patients are telling us we can and should do better. As positive experiences contribute to positive outcomes, we think this is an important component of our plan. We have a diverse community with specific needs across gender, age, race and religion. Identifying the needs and meeting them in a better fashion will help improve understanding and end results.

The San Antonio area generally lags the national average in publicly available patient experience and engagement scores. In fact, the most recent CMS data uploaded in October, 2012 indicates that San Antonio is significantly lower in every category than both the Texas and the U.S.
averages. Additionally, Methodist is consistently on the lower end of the spectrum when compared to its local peers.

Our campuses of Methodist Hospital have most recently individually approached patient experience improvement efforts, with little result. Trends have been flat and unsuccessful at changing the overall tone of the patient’s care. We feel that adding a dedicated position with ownership in the system, rather than through a consulting arrangement, will increase buy-in and drive results in a timely and effective manner.

This project address the Community Needs Assessment for this item:

CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

**Related Category 3 Outcome Measure(s):**

**TITLE OF OUTCOME MEASURE:** IT-6.1 Percent improvement over baseline of patient satisfaction scores

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Relationship to other Projects:**

This project is aligned with the wavier goals assuring patients receive high-quality and patient-centered care, in the most cost effective ways for all types of care. This project can interrelate with all Wavier projects.

**Relationship to Other Performing Providers’ Projects in the RHP:**

Unknown at this time.

**Plan for Learning Collaborative:**

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.
**Project Valuation:**

In determining the value of this project, Methodist analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, the effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.
<table>
<thead>
<tr>
<th>094154402.2.1 PASS 1</th>
<th>2.4.2</th>
<th>N/A</th>
<th>2.4.2 REDESIGN TO IMPROVE PATIENT EXPERIENCE</th>
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<tbody>
<tr>
<td>Methodist Hospital</td>
<td>TPI - 094154402</td>
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<tr>
<td>Related Category 3</td>
<td>094154402.3.3</td>
<td>3 IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
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<td>Outcome Measure(s):</td>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Milestone 1**
[P-1]: Appoint an executive accountable for experience performance

Metric [P-1.1]: Documentation of an executive assigned responsibility experience performance

Goal: Appoint MHS executive to be accountable for experience performance.

Data Source: Org Chart

Milestone 1 Estimated Incentive Payment: $1,183,717

**Milestone 2**
[P-4]: Integrate patient experience into employee training

Milestone 3

Metric [P-4.1]: Percent of new employees who received patient experience training as part of their new employee orientation

Goal: Increase percent of new employees who receive patient experience training as part of their new employee orientation by 2%

Data Source: Human Resources records (Numerator: Number of new employees receiving patient experience training/Denominator: Total number of new employees)

Milestone 3 Estimated Incentive Payment: $1,291,371

**Milestone 3**

Metric [P-4]: Integrate patient experience into employee training

Milestone 4

Metric [P-4.1]: Percent of new employees who received patient experience training as part of their new employee orientation

Goal: Increase percent of new employees who receive patient experience training as part of their new employee orientation by 2%

Data Source: Human Resources records (Numerator: Number of new employees receiving patient experience training/Denominator: Total number of new employees)

Milestone 4 Estimated Incentive Payment: $1,291,371

**Milestone 5**
[I-16]: Improve patient satisfaction/experience scores;

Metric [I-16.1]: Percent improvement of patient satisfaction scores for a specific tool over baseline 2012 by 2%. Baseline HCAHPS Score for 2012 = 69.6. National average for same time period unknown as of yet.

Goal: Improvement in experience scores will be the ultimate measure of success of improvement efforts.

Data Source: HCAHPS

Milestone 5 Estimated Incentive Payment: $2,590,251

**Milestone 6**
[I-16]: Improve patient satisfaction/experience scores;

Metric [I-16.1]: Percent improvement of patient satisfaction scores for a specific tool over baseline 2012 by 4%.

Goal: Improvement in experience scores will be the ultimate measure of success of improvement efforts.

Data Source: HCAHPS

Milestone 6 Estimated Incentive Payment: $2,139,773
<table>
<thead>
<tr>
<th><strong>Training</strong></th>
<th><strong>Milestone 4</strong></th>
</tr>
</thead>
</table>
| Metric [P-4.1]: Percent of new employees who received patient experience training as part of their new employee orientation. | **Goal**: Establish baseline  
**Data Source**: Human Resources records (Numerator: Number of new employees receiving patient experience training/Denominator: Total number of new employees)  
**Milestone 2 Estimated Incentive Payment**: $1,183,717 |
| **Metric [P-7.1]**: Submission of an assessment that includes answering questions such as: What areas of the organization have regular measures (e.g., inpatient vs. clinics vs. EDs); What methods are used to obtain experience data (e.g., mailed surveys vs. phone); What are the scores/findings for the organization as a whole?; What are the scores/findings by service line, location, and patient demographics?; What are the response rates by service line, location, and patient demographics?; and/or How are data stored, analyzed, fed back to the “sharp end” and used in quality improvement? | **Goal**: Determine Organizational baseline and improve by 2%.  
**Data Source**: Assessment  
**Milestone 4 Estimated Incentive Payment**: $1,291,372 |
<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $2,367,434</th>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,680,200</strong></td>
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</table>
**Identifying Project and Provider Information:**

| Title: 2.8.11 Apply Process Improvement Methodology to improve quality/efficiency: Sepsis |
| Unique RHP ID#: 094154402.2.2 – PASS 1 |
| Performing Provider: Methodist Hospital |
| Performing Provider TPI: 094154402 |

**Project Summary:**

Provider Description: Methodist Hospital, 45-0388, includes the campuses of six acute care hospitals: Methodist Hospital, Methodist Children’s Hospital, Methodist Specialty and Transplant Hospital, Northeast Methodist Hospital, Metropolitan Methodist Hospital, and Methodist Texan Hospital. For more than 49 years Methodist has provided high quality care to patients from San Antonio and throughout South Texas.

Intervention(s): This project will improve process methodology for Sepsis Bundles. Sepsis is a leading cause of hospital mortality in Bexar County.

Need for the project: Rationale for selecting this sepsis project is the high mortality rate in this population and the known evidenced-based care bundles for decreasing mortality in this population. The improvement requires significant planning, development of metrics, tools and education of all stakeholders.

Target population: Low income patients often have a delay in seeking care for infections which increase the chance for sepsis, and difficulty obtaining antibiotic therapy initially as well as post discharge. These elements will be measured with protocols developed to minimize these outcomes. A significant percentage of patients are either Medicaid and/or indigent patients and are expected to benefit from this project.

Category 1 or 2 expected patient benefits: The expected patient benefit is to improve the number of eligible patients that receive at least one (Resuscitation or Maintenance) Sepsis Bundle by 25% of baseline by DY5. The benefit of this project is to decrease the amount of patients who expire with sepsis. Approximately, 2500 patients per year are diagnosed with sepsis. We estimate that 50% of these will be eligible for Sepsis Bundles given their blood pressure and initial lactate levels. Approximately 18% of the 2500 patients diagnosed with sepsis annually are Medicaid recipients or uninsured.

Category 3 outcomes: Category 3, IT-4.8 Sepsis Mortality. Outcome measure will be Number of patients expiring during current month with sepsis / Number of patients identified that month with sepsis. Goal is to improve the mortality of eligible patients by at or below expected (observed/expected mortality ratio to 1.0 or lower) by DY5.

**Project Description:**

Sepsis is a leading cause of hospital mortality at Methodist Hospital. Our sepsis mortality are not statistically different than the risk-adjusted expected mortality rates, yet there is still opportunity for prevention, early recognition and aggressive care by well-defined sepsis care bundles.

This project involves care in the Emergency Department (ED), Critical Care Units (CCU), and regular in-patient unit. It involves nursing, laboratory staff, physicians, patients and families.

Patients with a diagnosis of Sepsis have a significant mortality. Early diagnosis and aggressive intervention with evidence based care protocols (care bundles) have been proven to significantly lower these patient’s mortality. The challenge is to set up systems of care in the Emergency Room and in-patient hospital to implement these proven strategies. The structured education,
protocols and electronic health record interventions will greatly enhance this process. This requires systems of coordinated, multi-disciplinary care that have traditionally been difficult in “silos” of the acute care hospital. The proposed interventions listed in this improvement project will ensure that this evidence-based care is provided in a timely and appropriate manner. Methodist understands that continuous quality improvement is at the heart of this project. Therefore, in the implementation of this project, Methodist will endeavor for continuous quality improvement by monitoring the patient volumes and patient utilization to ensure that progress is being made towards meeting the project milestones. Additionally, Methodist will ensure that all methodologies used will meet or exceed any applicable nationally recognized protocol or quality benchmarks.

Challenge: Sepsis is a rapid killer affecting millions of human population worldwide and studies have recorded that the mortality rate due to sepsis has been as alarming as one in four (or even more). It is a complex disease which is difficult to identify and treat. A challenge will be the ability to clearly define the disease and identify the targeted population of patients who will specifically benefit from that intervention. MHS plans to develop management strategies to ensure compliance with the sepsis bundles in order to decrease hospital mortality due to severe sepsis.

This project is aligned with the following Region 6 goals:

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

**Starting Point/Baseline:**
Baseline will be developed in DY3.

**Rationale:**
Rationale for selecting this sepsis project is the high mortality rate in this population and the known evidenced-based care bundles for decreasing mortality in this population. The improvement requires significant planning, development of metrics, tools and education of all stakeholders. This is expected to be a multiple year process. This addresses Category 2.8.11, Applying Process Improvement methodology to Improve Quality/Efficiency. Subsection of Sepsis Mortality IT – 4.8 Sepsis Mortality. This project is timely for our Hospital and has been identified as a key element in our Clinical Efficiency (CE) hospital plan.

This project address the Community Needs Assessment for these items:

CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.

CN.2 - A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes.
CN.3 - Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

Related Category 3 Outcome Measure(s):

Category 3, IT-4.8 Sepsis Mortality. The primary metric is risk-adjusted sepsis mortality. The risk-adjusted expected values for mortality, length of stay, and cost are calculated through regression analysis. Components include patients age, sex, zip code, primary and secondary diagnoses. This is a well validated tool for risk adjustment.

In addition to risk-adjusted improvements in sepsis mortality, we will be measuring the use of specific bundles of care (early recognition tool, resuscitation bundle, and management bundle) in the Emergency Department, Critical care unit, and in-hospital units.

Low income patients often have a delay in seeking care for infections which increased the chance for sepsis, and difficulty obtaining antibiotic therapy initially as well as post discharge. These elements will be measured with protocols developed to minimize these outcomes.

In Category 2, MHS will be measuring patients using the Sepsis Management Bundle [Evidence-based goals that must be completed within 24 hours for patients with severe sepsis, septic shock and/or lactate > 4 mmol/L (36 mg/dl)] with at least one sepsis bundle- Early Recognition Tool, Resuscitation or Maintenance. In Category 3, MHS will be measuring the number of patients expiring from sepsis divided by total sepsis patients.

Relationship to other Projects:

This project is related to other RHP interventions MHS 094154402.1.1- Telemedicine (1.7) for early diagnosis and intervention opportunities at remote sites, and expanding Specialty Care Capacity for improved hospital care and outpatient infection management.

Relationship to Other Performing Providers’ Projects in the RHP:

Sepsis is a common project in other hospitals in the region. The practices and outcomes will be shared across the region as well as nationally in peer reviewed publications. Regional Chief Medical Officers have a regular meeting to discuss shared clinical improvements, and sepsis is a frequent topic because of its cost and clinical impact.

Plan for Learning Collaborative:

Following completion of the RHP plan, University Health System (anchor) will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include goals, regular meetings, site visits, conference calls, communication plan development, organizing learning event, and adopt metrics to measure success.

Through the regional Chief Medical Officers forum sponsored by the Texas Hospital association,
best practices are shared and published on the THA website. The region-wide EMS system can also be involved in pre-hospital diagnosis and urgent intervention in sepsis. The community can be informed about sepsis through local media public relations and hospital newsletters.

<table>
<thead>
<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>In valuing this project, Methodist took into account the extent to which the Improvement in Sepsis would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.</td>
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</table>

The Improvement in Sepsis Mortality will **save lives of citizens in the community**. This directly addresses the goals by **implementing proven evidenced-based clinical methodology to improve care in this devastating illness**. Methodist took these factors into account when determine the incentive value of this project.”
<table>
<thead>
<tr>
<th>094154402.2.2 PASS 1</th>
<th>2.8.11 N/A</th>
<th>2.8.11 APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY: SEPSIS</th>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
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<td>3.1T-4.8 SEPSIS MORTALITY</td>
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<tr>
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<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
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<tr>
<td>Customizable Process</td>
<td>Customizable Process</td>
<td>Customizable Process</td>
<td>[I-X]: Improve Sepsis Bundle Utilization</td>
</tr>
<tr>
<td>Milestone[P-X]: There is not a milestone for the specific focus of this project- Sepsis</td>
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<td>Metric 1 [I-X.1]:</td>
</tr>
<tr>
<td>Metric 1 [P-X.1]: Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context</td>
<td>Metric 1 [P-X.1]: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan</td>
<td>Metric 1 [P-X.1]: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan</td>
<td>% of patients with severe sepsis, septic shock or sepsis with lactate &gt; 4 mmol/L with compliance of at least one entire sepsis bundle- Early Recognition Tool, Resuscitation or Maintenance.</td>
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<tr>
<td>Baseline/Goal: The goal to determine community needs.</td>
<td>Baseline/Goal: Develop intervention plan</td>
<td>Baseline/Goal: Develop intervention plan</td>
<td>Goal: Compliance with at least one Sepsis Bundle in 10% of patients from baseline.</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $2,367,434</td>
<td>Milestone 2 Estimated Incentive Payment: $1,291,371</td>
<td>Milestone 3 Estimated Incentive Payment: $1,291,371</td>
<td>Numerator: Patients diagnosed with severe sepsis, septic shock, and/or septic patients with lactate &gt; 4 mmol/L, where at least one Sepsis Bundle was used in its entirety.</td>
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<td><strong>Milestone 4</strong></td>
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<td>Goal: Compliance with at least one Sepsis Bundle in 10% of patients from baseline.</td>
<td>Goal: Compliance with at least one Sepsis Bundle in 25% of patients from baseline.</td>
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<td>Denominator: The total number of patients diagnosed</td>
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<tr>
<td>Metric 1 [P-X.1]: Develop baseline Sepsis Bundle compliance</td>
<td>Sepsis. with severe sepsis, septic shock, and/or septic patients with lactate&gt;4 mmol/L</td>
<td>shock, and/or septic patients with lactate&gt;4 mmol/L</td>
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<tr>
<td>Baseline/Goal: Develop baseline</td>
<td>Data Source: Hospital Data</td>
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<tr>
<td>Data Source: Hospital Data</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $9,680,200**
**Identifying Project and Provider Information:**

| Title: 2.1.1 Enhance/Expand Medical Homes: Nix Health Medical Homes |
| Unique RHP ID#: 112676501.2.1 – PASS 1 |
| Performing Provider: Nix Health Care System |
| Performing Provider TPI: 297342201 *(old TPI 112676501)* |

**Project Summary:**

**Provider Description:** Nix Health Care System is a 297 licensed bed (160 operating beds), multi-campus provider of inpatient and outpatient acute care services, psychiatric services, physical rehabilitation services and home care services. The primary service area is comprised of Bexar County, Texas and parts of the surrounding seven counties.

**Intervention(s):** This project will implement the Medical Home Model in at least 1 primary care clinic, to strengthen the clinician-patient relationship and replace the episodic care with coordinated care and long-term healing relationships.

**Need for the project:** Our region has identified community needs of (a) improved quality and patient satisfaction, (b) improved prevention and management of chronic diseases and (c) a documented health care shortage. We feel this project addresses each of these needs.

**Target population:** The clinic we have identified as being our first Medical Home is staffed by 2 Board Certified Geriatricians, as such, the target population of the clinic will be patients aged 55 and older. Most patients are expected to be Medicare-eligible patients, with approximately 15%-25% currently either Medicaid-eligible or dual-eligible. With the impending changes to the Medicaid eligibility, coupled with the increasing poverty rates among the elderly, this rate could be as high as 45-50% within the next few years.

**Category 1 or 2 expected patient benefits:** The project seeks to obtain Medical Home Accreditation by DY3 and achieve the goal of 85% of clinic patients being able to identify their usual source of care as being managed in a Medical Home by DY5. Since the physicians are new to the market, we expect the patient volume to grow over the next 3-5 years. We are expecting around 1,900 patients by the end of DY2, with a 10% increase annually over the next 3 years: 2,090 by end DY3, 2,299 by end DY4 and 2,529 by end DY5.

**Category 3 outcomes:**

- **IT.12.1** Our goal is to improve Breast Cancer Screening Rate (annual mammograms) for women aged 40 to 69 (improvement percentage TBD)
- **IT.12.3** Our goal is to improve Colorectal Cancer Screening Rate for adults aged 50 to 75 (improvement percentage TBD)
- **IT.12.4** Our goal is to improve Pneumonia Vaccination Status for adults aged 65 and older (improvement percentage TBD)
**Project Description:**

**Project Description**
Nix Health has recruited 2 new physicians to the market (Q4 DY1) and they plan to base their Provider Based Clinic around the Patient Centered Medical Home Model (PCMH). They are Family Practice physicians, and Board Certified in Geriatric Medicine. Their main clinic will be located in the medical offices of Nix Health in Downtown San Antonio, with some potential satellite locations throughout Bexar County. The physicians plan to center their practice around patients aged 55 and older. Due to the age of the expected patients for this clinic, we predict that a large percentage of patients will be Medicare-eligible, but we anticipate up to 25% of the patients to be Medicaid-eligible, dual-eligible or medically indigent. The patient navigator, which is a critical part of the PCMH Model, will help patients coordinate and receive the care they need in the most appropriate setting. This will be of particular importance for patients that may lack financial resources or family support.

The physicians are new to the market, and will be in a period of growth for 3-5 years while they build their patient base. For the valuation of this project, we are anticipating 1,900 unique patients by the end of DY2, with a 10% increase each year: 2,090 by end DY3, 2,299 by end DY4 and 2,529 by end DY5. Texas has one of the highest poverty rates in the nation, and the Supplemental Poverty Measure released by the U.S. Census Bureau in 2011 demonstrates that the official poverty measures drastically underestimate the poverty level for people aged 65 and older, as it does not take into account variations in health care spending across age groups despite differing health status, insurance coverage and rising medical costs in the elderly.

As we begin to implement the PCMH Model in this clinic, we will evaluate additional existing or new Provider Based Clinics for the PCMH model. The PCMH provides a “home base” for patients and a health care team tailors services to a patient’s unique health care needs, effectively coordinates the patient’s care across inpatient and outpatient settings, and proactively provides preventive, primary, routine, and chronic care. In RHP 6, quality improvements, patient satisfaction and the management of chronic diseases have been identified as key needs for the region (CN.1 & CN.2). The Nix Medical Homes will address all of these issues currently being faced within the region.

**Goals and Relationship to Regional Goals**
Over the course of the next 4 years, the Nix Medical Homes will improve patients’ access to care by striving to offer same-day appointments and will assist the patients in obtaining routine preventive care services, like annual wellness exams, vision screenings, mammograms, vaccines, etc. The Medical Home Care Team will also utilize alternative methods (telephone, group visits, etc.) to communicate with the patients.

**Project Goals:**
- Obtain medical home recognition by a nationally recognized agency
- Increase the percent of medical home patients that are able to identify their usual source of care as being managed in medical homes
- Expand interaction types between patients and healthcare team beyond on-to-one visits to include group visits, telephone visits, and other interaction types and focus these efforts on reaching patients within 2 business days of discharge to address any...
questions or concerns they have regarding their post-discharge medications and plan on care.

The project meets the following regional goals:
• Improve outcomes while containing cost growth
• Assuring patients receive high-quality and patient-centered care, in the most cost effective ways

Challenges
One of the biggest challenges we face in implementing a Medical Home Model is patient education regarding the differences between a Medical Home and a traditional primary care practice. This patient education will be an ongoing task.

5-year Expected Outcomes for Performing Provider and Patients
Nix Health expects to see a strengthened clinician-patient relationship that replaces episodic care with coordinated care and a long-term healing relationship. The physicians will lead care teams that take collective responsibility for patient care, preventive services, and making arrangements with other health care providers for specific needs. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Nix Health does not currently operate or partner with any Medical Homes, so this project will be a new undertaking with the patients currently served by the Medical Home model being zero. We plan to begin implementing the Medical Home methodologies and establish baselines and targets in DY2.

Rationale:
Reason for selecting this project
Primary care is a critical part of our healthcare continuum. Not only does primary care provide patients and physicians a preferred access point, it is critical to the patient’s ability to access needed services and other levels of care in an appropriate and efficient manner. Being underserved from a primary care standpoint (CN.3) creates barriers for patients, places undue burden on existing providers and encourages inappropriate utilization of health care resources which drives up health care costs and increases inefficiency. This fragmentation can be very confusing and burdensome to patients, especially those with chronic diseases (CN.2). The Nix currently does not operate any Medical Homes so we have elected Project Option 2.1.1.

While patients aged 55 and older are not typically the focus of Medicaid projects, it has been noted that Texas has one of the highest poverty rates in the nation at 17.8%. However, a recent report from the U.S. Census Bureau demonstrates that the official poverty measure drastically underestimates the poverty rate of the elderly, by not taking into consideration the rising medical costs, declining health status and insurance coverage. This report shows that the Supplemental Poverty Measure for the elderly was 75% higher than the Official Poverty Measure when these age variables were taken into consideration.
Project Components
Through the Nix Medical Home project, we propose to meet all of the required project components:

a) Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCP’s NCQA PCMH readiness
   Will compare NCQA PCMH requirements to the existing practices in place in the clinic and identify what would need to change within the existing clinic model in order to be compliant

b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
   Once we understand the gaps that exist, we will outline the necessary steps in order to become compliant with NCQA’s recommendations

c) Conduct educational sessions for primary care physician practice offices, hospital board of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision
   We will educate all key stakeholders on the steps that are necessary and the elements of a PCMH, as well as the expected outcomes.

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
   As we begin implementation we will continually review our results and identify opportunities to apply some or all of the Medical Home Models concepts to other primary care clinics in order to reach a broader patient population.

Milestones and Metrics Chosen
Since we are starting from a baseline of no Medical Homes, DY2’s milestones and metrics will focus on implementing the practices of a medical home, building our team, and educating our staff on PCMH change concepts. Once policies and practices are in place, we will begin some improvement milestones in DY3 which will also carry over to DY4 and DY5 with increasing targets in each subsequent year. The first improvement milestone we will track is the patient’s ability to identify the medical home as their usual source of care. The reason we selected this milestone is it speaks directly to the patient’s participation in the Medical Home concept. Without patient involvement, the model does not work as intended. Secondly, in DY3 we will implement a process milestone to track the current rate of identifying and reaching out to patients that need to be scheduled for preventive care. This milestone directly relates to our category 3 outcome improvement measures for DY4 and DY5. In DY5, an improvement milestone will be used to ensure we are reaching, at a minimum, the number of patients we expect to be reaching by that point in time. This milestone was chosen for DY5 since the clinic is still in its infancy and working to grow its patient base. And finally, we will also be tracking the process milestone of documented expanded interaction types beyond one-to-one visits as this is key to the patient feeling that they are getting the information and education in a format that is the most beneficial for them.
**Unique Community Needs Identification Numbers this project Addresses**

- CN.1 – Improve quality and patient satisfaction
- CN.2 – Improve prevention and management of chronic diseases
- CN.3 – Address health care shortage

The goal of the PCMH will be to improve quality (CN.1), improve patient satisfaction (CN.1), and improve prevention and management of chronic diseases (CN.2). Given that the physicians who are partnering with us for the implementation of the Medical Home are new to the region, we are also addressing the existing health care shortage (CN.3). We will identify lessons learned and opportunities to scale all or part of the medical home project to a broader patient population.

**How does this project represent a new initiative or significantly enhances an existing delivery system reform initiative.**

*Nix Health has not implemented or worked directly with any Medical Home Models in the past, so this is a new initiative.* This initiative, or related activities, is not being funded in whole or part by the U.S. Department of Health and Human Services.

**Related Category 3 Outcome Measure(s):**

OD-12 Primary Care and Primary Prevention

IT-12.1 Breast Cancer Screening: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period

IT-12.2 Colorectal Cancer Screening: Number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible Sigmoidoscopy every five years, Colonoscopy every 10 years

IT-12.4 Pneumonia vaccination status for older adults: Number of adults aged 65 and older that have ever received a pneumonia vaccine

One of the primary functions of the Medical Home will be to proactively provide preventive, primary, routine and chronic care and tracking these preventive screening initiatives directly correlates to the goal of the PCMH.

**Reason/rationale for selecting these outcome measures:**

As is outlined in the RHP6 Community Needs Assessment, there is a high prevalence of chronic disease and one of the leading causes of death is cancer. Through IT-12.1 and IT-12.2, patients will be encouraged to be proactive in the screening for cancer to improve their outcomes by catching the cancer sooner. The Pneumonia vaccination provides protection for older adults whose health could be jeopardized by pneumonia due to other chronic health conditions. Focusing on prevention improves outcomes and reduces the burden (physical, emotional, and financial) of more extensive disease. This is particularly important in low-income populations.
**Relationship to other Projects:**
Given that the 2 physicians that will be operating the Medical Home are newly recruited to the region, this project also relates to projects that fall under Category 1.1: Expand Primary Care Capacity. The physicians were recruited in DY1 and relocated to the area in Q4 DY1. However, given the nature of their practice heading towards the Medical Home Model, we felt it was best represented as a Category 2.1 project and incorporated the value of the expanded capacity into our valuation methodology.

The Nix Medical Home project is directly related to several Category 4 measures:
- Potentially Preventable Admissions: Through increased access to Primary Care and better methods to monitor patients’ chronic conditions, preventable admissions will be reduced (CHF, diabetes, behavioral health, COPD, Asthma, etc.)
- 30-Day Readmissions: When a patient has access to outpatient care post-discharge, the rate of readmission decreases. It will be vital to ensure that patients are scheduled for a follow-up appointment with the Medical Home physician shortly after discharge to ensure the patient has all of their questions answered pertaining to at-home care.
- Patient-centered healthcare: The Medical Home Model is centered around the patient, so inherently patient satisfaction and medication management will be improved.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Currently, for Pass 1 projects, both CHRISTUS Santa Rosa and University Health Systems have proposed projects that would allow them to expand their Medical Home Models. Nix Health will reach out to these other performing providers to share lessons learned and identify opportunities for improvement.

**Plan for Learning Collaborative:**
We plan to work with other Performing Providers from the region and participate in learning collaboratives, whether it be communicating via email, phone, webinars or face-to-face meetings.

**Project Valuation:**
The Medical Home Model will reduce the occurrence of duplicate tests and procedures and reduce overutilization of health care services and will reduce ER visits. A recent study on the outcomes of medical homes demonstration projects tracked the hospitalization reduction rate and ER visit reduction and estimated the total savings per patient enrolled in a medical home model being between $71 and $640, with some as high as $1,650 savings per year. For DY2 we have calculated this portion of the value as 1900 covered lives times $640 per year ($1,216,000 in DY2) and increasing 10% per year over the remaining years of the waiver.

Also, since these are new physicians to the market, and their clinic volume is not being valued separately in another DSRIP project, we can also assume value above and beyond the medical home model. Through adding Primary Care Clinics in underserved areas, access to quality care will be achieved. Currently, patients in underserved areas delay care until the condition worsens, and they seek care through Emergency Rooms which is more costly and less efficient. By adding physicians, separate and distinct from the medical home concept, we will be covering more lives and will see a reduction in ER visits. The geriatric patients they are serving are at
higher risk of ER visits and admissions so it is safe to assume each MD seeing patients would result in 20 fewer ER visits per month at a cost avoidance of $1,318\textsuperscript{2} per avoided ER visit by the end of DY5. Also, through expanded access to primary care on an outpatient setting, patients will be better able to manage their chronic diseases rather than delaying treatment and ultimately needing hospitalization. For each MD, we are conservatively estimating a reduction in need for admission by 10 per month by the end of DY5 at a cost avoidance of $5,359\textsuperscript{3} per avoided admission. We recognize that these physicians are new to the market and have not yet established a full patient panel so we have scaled back the valuation in DY2 to reflect only 4 avoided ER visits per month per MD and 2 avoided Med/Surg admissions per MD, for a DY2 value of $383,760. This, along with the valuation for Medical Homes brings the valuation for DY2 to $1,599,760 and this would increase to over $3.5M by DY5.

Footnotes:
\textsuperscript{1}Patient-Centered Primary Care Collaborative: The Outcomes of Implementing Patient-Centered Medical Home Interventions
\textsuperscript{2}Agency for Healthcare Research and Quality Medical Expenditure Panel Survey: Emergency Room Services
\textsuperscript{3}Texas Health and Human Services Commission, Potentially Preventable Readmissions in the Texas Medicaid Population Fiscal Year 2010

\textit{NOTE – Through our estimation, this project could be valued as high as $3.5M per year by DY5, but in order to stay in line with our Pass 1 allocation, we have valued it at $1,599,759 in DY2, $1,752,374 in DY3, $1,757,469 in DY4 and $1,451,822 in DY5}
### Related Category 3
#### Outcome
- Measure(s):
  - 112676501.3.1
  - 112676501.3.2
  - 112676501.3.3

### Nix Health Medical Homes

#### Primary Care and Primary Prevention: Breast Cancer Screening
#### Primary Care and Primary Prevention: Colorectal Cancer Screening
#### Primary Care and Primary Prevention: Pneumonia vaccination status for older adults

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt;[P-X] Implement the medical home model in primary care clinics&lt;br&gt;Metric 1 [P-X.1] Increase number of primary care clinics using medical home model&lt;br&gt;Baseline: 0 clinics participating in Medical Homes.&lt;br&gt;Goal: 1 clinic participating in Medical Homes&lt;br&gt;Data Source: Documentation of Medical Home Policies</td>
<td><strong>Milestone 5</strong>&lt;br&gt;[I-18]: Obtain medical home recognition by a nationally recognized agency&lt;br&gt;Metric 1 [I-18.1]: Medical home recognition/accreditation&lt;br&gt;Goal: 100% of the clinics eligible for recognition receive recognition&lt;br&gt;Data Source: Accreditation&lt;br&gt;Milestone 5 Estimated Incentive Payment: $438,093.50</td>
<td><strong>Milestone 9</strong>&lt;br&gt;[I-15]: Increase the percent of medical home patients that are able to identify their usual source of care as being managed in medical homes&lt;br&gt;Metric [I-15.1]: Usual source of care&lt;br&gt;Baseline to be established in DY2.&lt;br&gt;Goal is 70% for DY3&lt;br&gt;Data Source: Patient Surveys&lt;br&gt;Milestone 9 Estimated Incentive Payment: $878,734.5</td>
<td><strong>Milestone 11</strong>&lt;br&gt;[I-15]: Increase the percent of medical home patients that are able to identify their usual source of care as being managed in medical homes&lt;br&gt;Metric [I-15.1]: Usual source of care&lt;br&gt;Baseline to be established in DY2.&lt;br&gt;Goal is 85% for DY3&lt;br&gt;Data Source: Patient Surveys&lt;br&gt;Milestone 11 Estimated Incentive Payment: $483,940.66</td>
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<tr>
<td><strong>Milestone 2</strong>&lt;br&gt;[P-4] Develop staffing plan to expand primary care team roles; Expand and redefine roles and</td>
<td><strong>Milestone 6</strong>&lt;br&gt;[I-15]: Increase the percent of medical home patients that are able to identify their usual source of care as being managed in medical homes&lt;br&gt;Metric [I-15.1]: Usual source of care&lt;br&gt;Baseline to be established in DY2.</td>
<td><strong>Milestone 10</strong>&lt;br&gt;[P-10]: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other</td>
<td><strong>Milestone 12</strong>&lt;br&gt;[P-10]: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other</td>
</tr>
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</table>
**responsible of primary care team members**

**Metric [P-4.1]** Expand primary care team roles

Baseline: 0% of Medical Home roles defined

Goal: 100% of the Medical Home roles defined

Data Source: Revised Job Descriptions

Milestone 2 Estimated Incentive Payment: $399,939.75

**Milestone 3**

[P-9] Train medical home personnel on PCMH change concepts

**Metric [P-9.1]** Number of Medical Home Personnel Trained

Baseline: 0% of staff currently trained

Goal: 100% of the Medical Home Personnel Trained

Data Source: Training Records

Milestone 3 Estimated Incentive Payment: $399,939.75

**Goal is 50% for DY3**

Data Source: Patient Surveys

Milestone 6 Estimated Incentive Payment: $438,093.50

**Milestone 7**

[P-10]: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other interaction types

**Metric [P-10.2]** Percent of hospitalized patient who have clinical, telephonic, or face-to-face follow-up interaction with the care team within 2 [business] days of discharge during the measurement month at sites that implement complex care management.

Goal: 70%

Numerator: Number of patients receiving follow up care within 2 business days of discharge

Denominator: Number of discharged patients

Data Source: EHR

Milestone 7 Estimated Incentive Payment: $399,939.75

Milestone 10 Estimated Incentive Payment: $878,734.5

**Milestone 13**

[I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.

**Metric [I-12.1]** Number of eligible patients assigned to a medical home.

Goal: 2,500 Total Unique Patients

Numerator: Number of eligible patients assigned to a medical home
<table>
<thead>
<tr>
<th>Milestone 4</th>
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<th>Milestone 8</th>
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<th>Milestone 13</th>
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<tbody>
<tr>
<td>[P-10]: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other interaction types</td>
<td>Payment: $438,093.50</td>
<td>[P-11]: Identify utilization rates of preventive services and implement a system to improve rates among targeted population</td>
<td></td>
<td>Estimated Incentive Payment: $483,940.66</td>
</tr>
<tr>
<td>Metric 1 [P-10.2] Percent of hospitalized patient who have clinical, telephonic, or face-to-face follow-up interaction with the care team within 2 [business] days of discharge during the measurement month at sites that implement complex care management.</td>
<td></td>
<td>Metric 1 [P-11.2]: Implement a recall system that allow staff to report which patients are overdue for which preventive services and track when and how patients were notified on their needed services</td>
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<tr>
<td>Goal: 50%</td>
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<td>Baseline: No current recall system</td>
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<tr>
<td>Numerator: Number of patients receiving follow up care within 2 business days of discharge</td>
<td>Goal: Submit a recall report showing baseline rate for compliance with preventive services</td>
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<tr>
<td>Denominator: Number of discharged patients</td>
<td>Data Source: EHR</td>
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<tr>
<td>Data Source: EHR</td>
<td>Milestone 4 Estimated Incentive Payment: $399,939.75</td>
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</table>

| Year 2 Estimated Milestone Bundle Amount: $1,599,759 | Year 3 Estimated Milestone Bundle Amount: $1,752,374 | Year 4 Estimated Milestone Bundle Amount: $1,757,469 | Year 5 Estimated Milestone Bundle Amount: $1,451,821.98 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,561,423.98
### Identifying Project and Provider Information:

| Title: 2.8.1 Design, develop, and implement a program of continuous rapid process improvement that will address issues of safety, quality, and efficiency within the Nix Geriatric Med/Surg Inpatient Population |
| Unique RHP ID#: 112676501.2.2 – PASS 1 |
| Performing Provider: Nix Health Care System |
| Performing Provider TPI: 297342201 *(old TPI 112676501)* |

### Project Summary:

**Provider Description:** Nix Health Care System is a 297 licensed bed (160 operating beds), multi-campus provider of inpatient and outpatient acute care services, psychiatric services, physical rehabilitation services and home care services. The primary service area is comprised of Bexar County, Texas and parts of the surrounding seven counties.

**Intervention(s):** This project will utilize continuous rapid process improvement programs to identify and implement best practices that will help improve the safety, quality and efficiency of the care for our geriatric patients during hospitalization. Physicians will be educated on the findings, and encouraged to admit their medical/surgical elderly patients to the ACE Program (Acute Care for the Elderly) where these process improvement interventions will be applied and the patient will be cared for using an interdisciplinary team approach.

**Need for the project:** Texas as a whole ranks last in the nation in health care quality and our region in particular has a high prevalence of chronic disease in the elderly. This project will address the patient holistically during their hospitalization rather than focusing solely on the acute illness. And while patients age 65+ are not typically the focus of a Medicaid-related program, it cannot be ignored that Texas ranks as one of the highest in the nation for poverty, with the elderly being at great risk for poverty given their declining health status and increasing medical costs. A recent report from the U.S. Census Bureau in 2011 demonstrates that the official poverty measure drastically underestimates the poverty level of the elderly since age-related variables are not taken into consideration. The report indicates that the Supplemental Poverty Measure is 75% higher for the elderly than the official poverty measure.

**Target population:** This project targets mostly Medicare-eligible patients, but historically 15% to 25% of our medical/surgical admissions for patients aged 65 and older have been dual-eligible or medically indigent. However, the above-referenced U.S. Census Bureau report indicates that the percent of medically-indigent elderly patients may be much higher than the percentage that are Medicaid- or dual-eligible. The declining health status and increasing medical costs place the elderly at great risk of poverty and this project’s goal of improved health outcomes during hospitalization will help address some of the risk factors associated with poverty in the elderly. With the impending changes to the Medicaid program, coupled with the increasing poverty rates among the elderly, this rate could be as high as 45-50% within the next few years.

**Category 1 or 2 expected patient benefits:** The project seeks to have at least 55% of our medical/surgical (non-ICU) patients enrolled in the ACE Program by DY5. In DY1, Nix Health had 1,336 Med/Surg (non-ICU) patients that were aged 65+. This volume is expected to grow, but conservatively we expect to treat 735 patients using the ACE model annually in DY5.
Category 3 outcomes: IT.3.1 Our goal is to reduce all-cause 30-day readmission rates for patients admitted to the ACE Program (improvement target percentage TBD)

**Project Description:**

**Project Description**

In DY1, nearly half of the med/surg patients admitted to Nix Health that were not ICU patients were age 65 and older, and that percentage is expected to grow in the coming years. Recognizing this, and the challenges that are faced by elderly patients when they are hospitalized, we plan to test and implement measures related to this group of patients. Similar to the process improvement practices implemented by the NICHE program, we will identify evidence based practices that may help improve the safety, quality and efficiency of the geriatric patients during their hospitalization, and work to incorporate these practices into the care these patients receive during their stay and post-discharge.

Nix Health has begun testing some of these performance improvement initiatives in DY1 with a select group of patients. Internally these patients have been categorized as “ACE” patients, which stands for Acute Care of the Elderly. We have been operating a Virtual ACE Program (not tied to a specific physical location) for select physicians’ elderly patients during a trial period (DY1) and our plan is to expand and open the ACE Program to any physician for their Medical or Surgical patients aged 65+ while we continue to test and implement evidence-based practices to improve their quality and outcomes.

In DY1, Nix Health treated 1,336 Med/Surg, non-ICU patients that were aged 65+. As the elderly population grows and Nix development efforts successfully increase Med/Surg volume, we expect that number to increase over the next few years. However, conservatively holding that figure constant, we expect to treat 45% of these patient using these ACE protocols by DY3 (601 patients annually) and increasing to 55% by DY5 (735 patients annually).

While patients aged 65 and older are not typically the focus of Medicaid projects, it has been noted that Texas has one of the highest poverty rates in the nation at 17.8%. However, a recent report from the U.S. Census Bureau demonstrates that the official poverty measure drastically underestimates the poverty rate of the elderly, by not taking into consideration the rising medical costs, declining health status and insurance coverage. This report shows that the Supplemental Poverty Measure for the elderly was 75% higher than the Official Poverty Measure when these age-related variables were factored in.

**Goals and Relationship to Regional Goals**

Research has shown that the ACE model, which is dedicated to recognizing the unique needs of geriatric patients through a collaborative team-based approach, allows elderly patients to avoid the functional decline that can occur during hospitalization. The overarching goal of the ACE program is to allow patients to return to the living situation they had been in prior to entering the hospital.

Over the course of the next 4 years, Nix Health will implement evidence-based practices aimed at improving the quality, safety and efficiency of care given to these elderly patients.
Project Goals:

- In DY2, we will identify target metrics that we will be tracking, such as LOS, medication costs, falls, discharges to ‘home’, etc. and develop a dashboard to allow us to track these metrics effectively over time.
- Also, we will continue to engage our physicians in the concepts of affecting outcomes through evidence-based practices and encouraging them to utilize the ACE program for their elderly patients.
- We will continually review and analyze the data, and identify at least one area of improvement annually. We will then research and implement evidence-based approaches to impact the identified improvement target. We will subsequently report on our findings to our key stakeholder.
- To measure our progress toward goal, we will annually measure the percent of med/surg admissions (non-ICU) aged 65+ that are admitted through the ACE program as a measurement of our physician engagement with the program and its concepts.

The project meets the following regional goals:

- Improve outcomes while containing cost growth
- Assuring patients receive high-quality and patient-centered care, in the most cost effective ways

Challenges

The biggest hurdle we face in expanding the program is to educate the physicians on what the program is and how it can benefit their patients. During DY1 we have met with some resistance from physicians who feel that an interdisciplinary team approach to patient care can be intrusive into their thoughts on how to practice medicine, so we are continually educating our physicians on what the program is and the benefits it can have on their patients.

5-year Expected Outcomes for Performing Provider and Patients

Through increased physician education and improved understanding and by sharing the findings of our own internal process improvements, our goal over the 5 years is to have at least 55% (735) of the Med/Surg patients age 65+ admitted through the ACE program by DY5. This project is directly related to the regional goal of improving quality and patient satisfaction (CN.1)

Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

Using DY1 (Oct 2011-Sept 2012) as the starting point, Nix Health had 2,903 Med/Surg Admissions (all ages) and 134 of those were ICU patients. Of the 2,769 non-ICU patients, 1,336 were 65+ (48%). However, only 157 were admitted to the ACE program which equates to 12% of the age 65+ non-ICU admissions. Our goal for DY3 is to have 45% of the age 65+ non-ICU med/surg admissions be admitted to the ACE program, with that percentage increasing to 55% by DY5 (735 patients annually).
Rationale:

**Reason for selecting this project**

Nix Health feels this project is an integral part of addressing the needs of our community. As stated in the RHP6 Community Needs Assessment, Texas ranks last in the nation on health care quality (CN.1) and this project will improve both quality and patient satisfaction. Also, there is a high prevalence of chronic disease in our aging population (CN.2) and addressing the needs of the elderly during their hospitalization will assist them post-discharge as well. While this project could have been divided up into other smaller projects, like a stand-alone Care-Transitions Program Implementation, or Medication Management process improvement, we felt the initiatives being undertaken by Nix Health to improve the safety, quality and outcomes of the geriatric population were best suited to the Category 2.8 project of *Design, develop, and implement a program of continuous rapid process improvement that will address issues of safety, quality, and efficiency*. This project will allow us to incorporate medication management and care transitions programs, along with other interventions, to address multiple needs of the aging population.

And while patients aged 65 and older are not typically the focus of Medicaid projects, it has been noted that Texas has one of the highest poverty rates in the nation at 17.8%. However, a recent report from the U.S. Census Bureau demonstrates that the official poverty measure drastically underestimates the poverty rate of the elderly, by not taking into consideration the rising medical costs, declining health status and insurance coverage. This report shows that the Supplemental Poverty Measure for the elderly was 75% higher than the Official Poverty Measure when these age-related variables were factored in.

**Project Components**

Through this project, we propose to meet all of the required project components:

a. *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.*

   Will conduct training sessions with staff who will be involved in implementing, measuring and reporting performance improvement strategies

b. *Develop an employee suggestion system that allows for identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.*

   All employees will be empowered to provide suggestions for ways we could improve patient care or efficiencies in our workflow.

c. *Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis dissemination of performance on these measures.*

   These key metrics will be identified in DY2 and will be used to build the monthly dashboard that will allow us to track our progress against our targets

d. *Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.*

   This will be integrated into the training provided to clinical and administrative staff pertaining to the process improvement strategies

e. *Implement software to integrate workflows and provide real-time performance feedback.*

   As we are able, we will include information into our EMR and nurse documentation
system to prompt nursing staff with reminders for specific interventions to provide real-time feedback.

f. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators. Utilizing the dashboard and other tools to measure our progress, we will continually compare our outcomes to what we expected to see based on the evidence-based interventions implemented. As necessary, we will make modifications to our plan and will also continuously evaluate ways that the successful interventions can be applied to other patient populations.

**Milestones and Metrics Chosen**
While not a new program, the ACE Program has only been in a trial period for DY1 and expanding the program significantly enhances the reach and thereby the benefit it will offer to our patients. The milestones and metrics we have chosen are directly related to the core project components and goals we plan to achieve.

**Unique Community Needs Identification Numbers this project Addresses**
- CN.1 – Improve quality and patient satisfaction
- CN.2 – Improve prevention and management of chronic diseases

Texas ranks last in the nation on health care quality, and the very nature of this project is focused on improving quality and patient satisfaction. Also, there is a high prevalence of chronic diseases, particularly among the elderly, and through this project we will be address the patient as a whole during their hospitalization rather than only focusing on their acute ailment and this will help improve the management of chronic conditions.

**How does this project represent a new initiative or significantly enhances an existing delivery system reform initiative.**
While not a new initiative, the evidence-base components of the ACE program were just recently implemented at Nix Health during DY1 and the expansion from 12% to 55%+ signifies a significant enhancement to the existing delivery. Some of the patients currently admitted to the ACE program in DY1 have also been part of a Community-based Care Transitions Program that was funded by a grant from a CMS demonstration project. This funding ended in Sept 2012, so no other federal funds are being used for this project. Nix Health is considering implementing a Care Transitions Program internally for the ACE patients at high-risk for re-visitation.

**Related Category 3 Outcome Measure(s):**
- OD-3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRs)
- IT-3.1 All cause 30 day readmission rate – NQF 1789 (standalone measure)

**Reason/rationale for selecting these outcome measures:**
Through the ACE program, a collaborative interdisciplinary team-based approach will be utilized (physician, case manager, physical and occupational therapy, pharmacy, etc.) to address the full spectrum of the patient’s needs during their stay. Through improved processes regarding patient and family education and post-discharge follow-up, the readmissions for this population should be reduced.
**Relationship to other Projects:**
This project is directly related to our Medical Home Project (Category 2.1) in that the patients of the Medical Home physicians will be admitted through the ACE program and will be managed during their stay by an interdisciplinary team.

Also, this project directly relates to several Category 4 projects:

- **Potentially Preventable Admissions:** By treating the whole patient, and not just the current alignment, we will be reducing the need for further hospitalization. Involvement of the family and care givers during the hospitalization and with the patient education is crucial to helping the patient stay healthy when at home post-discharge.
- **30-Day Readmissions:** During the admission to the ACE program, the interdisciplinary team will do a thorough review of the patient’s medication and will perform a ‘reset’ to ensure the patient is not discharged with duplicative or redundant medications. Research has shown that patients who are discharged on 5 or more medications have a higher rate of readmission, most likely due to the confusing nature of having to take multiple medications on various schedules.
- **Patient-centered healthcare:** By addressing the full needs of the patient and working diligently to ensure that they do not lose unnecessary daily living skills during their hospitalization, patient satisfaction will be increased.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Other performing providers are planning projects that fit within Category 2.8, but the details of those projects are not yet fully disseminated. While performance improvement projects may be a shared theme, the details of the specific projects may not lend themselves as easily to learning collaborative opportunities within the region, but we will utilize other resources that are closely related to the ACE or NICHE type programs.

**Plan for Learning Collaborative:**
TBD

**Project Valuation:**
The Nix Health ACE program will coordinate treatment plan amongst providers and reduce LOS by 1 day (cost avoidance of $1,900\(^1\) per day) and through collaboration will result in a reduction of Adverse Drug events by 7 per 100 admissions (cost avoidance of $16,000\(^2\) per ADE). Improvement in patient satisfaction can be related to improvement in communication and increased patient/family involvement in their care. Patients that are more involved in their care and understand their discharge instructions will be less likely to be readmitted within 30 days. The use of the ACE model also reduces the incidence of delirium from 40.8% down to 26%\(^3\) with a savings of $2,181\(^3\) per case. In addition, the cost of caring for patients post-discharge (home medications, post-acute facility costs, etc.) will be decreased at an annual savings estimated at $500\(^4\) per patient.

Conservatively assuming volume is flat and meeting targets of ACE patients as percent of total age 65+:
- Reduced LOS by 1 day per patient enrolled in program ($1,900\(^1\) each)
- Avoid 7 ADEs per 100 admissions to the program ($16,000\(^2\) each)
- Reduce readmission rate through medication evaluation and total ‘reset’ and improved
communication with patient, family and care givers ($9,600 each\(^5\))
- Reduce delirium rate from 40.8% down to 26% ($2,181\(^3\) each)
- Reduce post-discharge costs (home medications, post-acute care facilities, etc. ($500\(^4\) per patient)

Goal for DY2 would be 40% of the age 65+ non-ICU med/surg admissions would be admitted through the ACE program (approximately 44 patients per month in DY2). Applying these values, the total value for DY2, would be $2,440,299 and this would increase as the volume of patients admitted through the ACE program continues to increases. The goal for DY3 would be 45%, DY4 50% and 55% by DY5. In order to align the milestones with the actual expected patient impact, we have converted these percentages to actual figures for DY3-DY5:
- 600+ patients in DY3
- 668+ patients in DY4
- 735+ patients in DY5

Footnotes
1 Internal Metric
2 Agency for HealthCare Research and Quality: Reducing and Preventing Adverse Drug Events To Decrease Hospital Costs http://www.ahrq.gov/qual/aderia/aderia.htm
4 Conservative estimate

**NOTE** – Through our estimation, this project could be valued as high as $3.3M per year by DY5, but in order to stay in line with our Pass 1 allocation, we have valued it at $2,440,300 in DY2, $2,655,113 in DY3, $2,662,831 in DY4 and $2,199,730 in DY5
### 2.8.1 DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS RAPID PROCESS IMPROVEMENT THAT WILL ADDRESS ISSUES OF SAFETY, QUALITY, AND EFFICIENCY WITHIN THE NIX GERIATRIC MED/SURG INPATIENT POPULATION

**Related Category 3 Outcome Measure(s):**
- 112676501.3.4
- 3.IT-3.1

**Potentially Preventable Re-Admissions – 30 day Readmissions**
- All cause 30 day readmission rate – NQF 1789 (standalone measure)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt; [P-2] Identify/target metric to measure impact of process improvement methodology and establish baseline&lt;br&gt; <strong>Metric 1</strong> [P-2.1] Performing Provider identification of impact metrics and baseline&lt;br&gt; Baseline: No targets have been identified&lt;br&gt; Goal: Submission of Report which may include LOS, Medication Cost, Fall rate, readmission Rate, etc.&lt;br&gt; Data Source: TBD</td>
<td><strong>Milestone 4</strong>&lt;br&gt; [P-3] Compare and analyze clinical/quality data and identify at least one area for improvement&lt;br&gt; <strong>Metric</strong> [P-3.1] Analysis and identification of target area&lt;br&gt; Baseline: improvement area has not been identified&lt;br&gt; Goal: Submission of analysis of findings/summary and identification of target area.&lt;br&gt; Data Source: Analysis</td>
<td><strong>Milestone 7</strong>&lt;br&gt; [P-3] Compare and analyze clinical/quality data and identify at least one area for improvement&lt;br&gt; <strong>Metric</strong> [P-3.1] Analysis and identification of target area&lt;br&gt; Baseline: improvement area has not been identified&lt;br&gt; Goal: Submission of analysis of findings/summary and identification of target area.&lt;br&gt; Data Source: Analysis</td>
<td><strong>Milestone 10</strong>&lt;br&gt; [P-3] Compare and analyze clinical/quality data and identify at least one area for improvement&lt;br&gt; <strong>Metric</strong> [P-3.1] Analysis and identification of target area&lt;br&gt; Baseline: improvement area has not been identified&lt;br&gt; Goal: Submission of analysis of findings/summary and identification of target area.&lt;br&gt; Data Source: Analysis</td>
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<tr>
<td><strong>Milestone 2</strong>&lt;br&gt; [P-3] Compare and analyze clinical/quality data and</td>
<td><strong>Milestone 5</strong>&lt;br&gt; [P-12]: Report findings and learnings&lt;br&gt; <strong>Metric</strong> [P-12.1]: Final report/report summary</td>
<td><strong>Milestone 8</strong>&lt;br&gt; [P-12]: Report findings and learnings&lt;br&gt; <strong>Metric</strong> [P-12.1]: Final report/report summary</td>
<td><strong>Milestone 11</strong>&lt;br&gt; [P-12]: Report findings and learnings&lt;br&gt; <strong>Metric</strong> [P-12.1]: Final report/report summary</td>
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</table>

**Milestone 1 Estimated Incentive Payment:** $813,433.33

**Milestone 4 Estimated Incentive Payment:** $885,037.66

**Milestone 7 Estimated Incentive Payment:** $887,610.33

**Milestone 10 Estimated Incentive Payment:** $733,243.33

**Milestone 5 Estimated Incentive Payment:** $885,037.66

**Milestone 8 Estimated Incentive Payment:** $887,610.33

**Milestone 11 Estimated Incentive Payment:** $733,243.33
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<tr>
<th>Metric</th>
<th>Analysis and identification of target area</th>
<th>Baseline: improvement area has not been identified Goal: Submission of analysis of findings/summary and identification of target area. Data Source: Analysis</th>
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<tbody>
<tr>
<td><strong>Milestone 2</strong></td>
<td>Estimated Incentive Payment: $813,433.33</td>
<td><strong>Milestone 5</strong> Estimated Incentive Payment: $885,037.66</td>
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<tr>
<td><strong>Milestone 3</strong></td>
<td>[P-10] Develop a quality dashboard that will quantify and determine the quality of care provided Metric [P-10.1] Submission of quality dashboard development, utilization and results. Baseline: no current dashboard Goal: Submission of a quality dashboard Data Source: Dashboard</td>
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<td><strong>Milestone 6</strong></td>
<td>Number of relevant clinical cases at target Baseline/Goal: Goal is 600+ med/surg, non-ICU patients age 65+ are admitted to the ACE Program Numerator... Total med/surg admissions (non-ICU) for patients age 65+ that are categorized as ‘ACE’ patients Data Source: Clinical Records</td>
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<tr>
<td><strong>Milestone 7</strong></td>
<td>Estimated Incentive Payment: $885,037.66</td>
<td><strong>Milestone 8</strong> Estimated Incentive Payment: $887,610.33</td>
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<tr>
<td><strong>Milestone 9</strong></td>
<td>Number of relevant clinical cases at target Baseline/Goal: Goal is 668+ med/surg, non-ICU patients age 65+ are admitted to the ACE Program Data Source: Clinical Records</td>
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<tr>
<td><strong>Milestone 10</strong></td>
<td>Estimated Incentive Payment: $887,610.33</td>
<td><strong>Milestone 11</strong> Estimated Incentive Payment: $733,243.33</td>
</tr>
<tr>
<td><strong>Milestone 12</strong></td>
<td>Number of relevant clinical cases at target Baseline/Goal: Goal is 735+ med/surg, non-ICU patients age 65+ are admitted to the ACE Program Data Source: Clinical Records</td>
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<tr>
<td><strong>Milestone 13</strong></td>
<td>Estimated Incentive Payment: $733,243.33</td>
<td><strong>Milestone 14</strong> Estimated Incentive Payment: $733,243.33</td>
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<td>Year 2 Estimated Milestone</td>
<td>Year 3 Estimated Milestone</td>
<td>Year 4 Estimated Milestone</td>
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</tr>
<tr>
<td>Bundle Amount: $2,440,300</td>
<td>Bundle Amount: $2,655,113</td>
<td>Bundle Amount: $2,662,831</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $9,957,974
Identifying Project and Provider Information:
Title: 2.9.1 Establish a Patient Care Navigation Program
Unique RHP ID#: 112676501.2.3 – PASS 2
Performing Provider: Nix Health Care System
Performing Provider TPI: 297342201 (old TPI 112676501)

Project Summary:
Provider Description: Nix Health Care System is a 297 licensed bed (160 operating beds), multi-
campus provider of inpatient and outpatient acute care services, psychiatric services, physical
rehabilitation services and home care services. The primary service area is comprised of Bexar
County, Texas and parts of the surrounding seven counties.

Intervention(s): This project will implement a Patient Navigator Program to assist patients in
taking control of their chronic diseases

Need for the project: Our region has a shortage of medical and mental health care providers, as
well as the lowest scores in the nation for healthcare quality. Through the Patient Navigator
Program, we will facilitate connections between patients and the resources they need, including
Primary Care Physicians, Specialists, Behavioral Health service and community programs.

Target population: This project targets patients with chronic diseases and those that are at
greatest risk of disconnect from the health care system. Our overall patient base is roughly 20%
Medicaid-eligible/medically indigent, but we anticipate that Medicaid and/or medically indigent
patients will comprise at least 50% of the patients enrolled in the program.

Category 1 or 2 expected patient benefits: The project seeks to have 600 unique patients enrolled
in the program by DY3, with that figure increasing to 900 by DY5

Category 3 outcomes: IT.9.2 Our goal is to reduce ED utilization for diabetes-related issues
among enrollees of the Patient Navigator Program (reduction percentage TBD)

Project Description:

Project Description
Nix Health plans to implement a Patient Navigator Program to help patients and their families
navigate the fragmented maze of the healthcare system, including primary care physician offices,
specialists, preventive screenings, diagnostic testing, inpatient admissions, payment systems, and
community resources. During DY2 we will conduct studies within our Provider-Based Clinic
offices to identify the targeted patient populations and chronic conditions that we will be
focusing on through the Patient Navigator Program.

Goals and Relationship to Regional Goals
Over the next 4 years, Nix Health will strive to serve our patients better through the Patient
Navigator Program to improve outcomes, increase patient satisfaction, and reduce fragmentation
of care. The primary goal of the Patient Navigator will be to allow the patient to focus on taking
charge of their chronic diseases rather than focusing their efforts on finding their way through
the health care system.
Project Goals:
- Define and implement a Patient Navigator Program
- Work with our physicians to educate them on the role of the Patient Navigators so they can understand who and when to refer to the program, thereby increasing enrollment and the number of lives we can impact through this initiative
- Monitor ED utilization and identify high ED utilizers or patients that are using the ED for episodic care and educate them on available Primary Care Physicians available to them

The project meets the following regional goals:
- Improve outcomes while containing cost growth
- Assuring patients receive high-quality and patient-centered care, in the most cost effective ways

Challenges
There are several patient populations that could be drastically improved by a Patient Navigation Program, so they first challenge we will face will be to identify how and where to start the program so we can be efficient and targeted. Patient Navigation is most predominant in cancer programs, but we plan on expanding it to other diseases, like diabetes or COPD. While it will be tempting to address all conditions, this would prove impractical and would spread our staff too thin and the assistance provided to patients would be less effective than if we take a targeted approach. As we learn about the implementation process, we can then roll the process out to other patient populations.

Another challenge we will face will be patient compliance. We will be working with patients that are highly vulnerable and at risk of being disconnected from the health care system. Our challenge and goal will be to get these patients engaged in their own health so that we can provide as much assistance as possible and make the most impact on their outcomes. However, due to their high risk and vulnerability, it may prove challenging to keep them engaged for the long term.

5-year Expected Outcomes for Performing Provider and Patients
Nix Health expects that this project will strengthen the relationship between patients and physicians and will allow physicians more time to dedicate to patient care by providing an extension of their practice to their patients. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Nix Health does not currently operate a Patient Navigator program, and plan to research and begin implementation during DY2

Rationale:

Reason for selecting this project
Fragmentation is prevalent in our region’s health care delivery system. Patients can easily get lost and overwhelmed by this fragmentation, which can create barriers to timely care, cause patients to delay seeking treatment, and ultimately result in poorer outcomes. Nix Health sees Patient Navigators as a way to reduce this fragmentation and allow patients to receive timely care and improve outcomes. Given that Nix Health does not currently operate a Patient Navigator Program, we have elected Project Option 2.9.1.
Project Components
Through this project, we propose to meet all of the required project components:

a. **Identify frequent ED users and use navigators as part of a preventable ED reduction program.** Train health care navigators in cultural competency
   Nix Health is opening an ED in late 2012 and will immediately begin tracking ED utilization rates. As we begin building the Patient Navigator Program, they will play a key role in helping these ED high utilizers understand the other primary care options that are available to them.

b. **Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.**
   As we research and define our Patient Navigator Program, we will identify the types of care providers that will be needed for the program. We expect it will be a mix of types of health professions.

c. **Connect patients to primary and preventive care.**
   One of the main goals of the Patient Navigator Program will be to connect patients with primary care physicians and clinics and educate them about preventive care options. While we have not yet identified the patient population that the Patient Navigator Program will serve, it will undoubtedly be patients with some chronic conditions and primary and preventive care will play a key role in the outcomes for these patients.

d. **Increase access to care management and/or chronic care management, including education in chronic disease self-management**
   Chronic care management will be essential to helping the Patient Navigator Program enrollees take charge of their healthcare. We will work with community resources and our own internal resources to identify education opportunities for patients to meet their needs.

e. **Conduct quality improvement for project using methods such as rapid cycle improvement.** Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
   As part of the implementation, and throughout the life of the Patient Navigation Program, we will continually assess the impacts our interventions are having and review the lessons learned. As necessary, we will make changes to our approach and look for ways to expand the project to reach a broader set of patients.

Milestones and Metrics Chosen
The milestones and metrics we have chosen are directly related to the core project components and goals we plan to achieve.

Unique Community Needs Identification Numbers this project Addresses
- CN.1 – Improve quality and patient satisfaction
- CN.2 – Improve prevention and management of chronic diseases
- CN.3 – Improve access to medical care for those underinsured by facilitating the
connection between patient and physician to minimize the impact of the provider shortage

• CN.4 – Minimize shortage of mental and behavioral health services by helping patients navigate to available services that meet their needs.
• CN.6 – connecting patient with preventive services, like screening and vaccinations, will help address the high rates of vaccine-preventable diseases

Our region has a shortage of medical and mental health care providers, as well as the lowest scores in the nation for healthcare quality. Through the Patient Navigator Program, we will facilitate connections between patients and their needed resources, ranging from Primary Care Physicians, Specialists, Behavioral Health service and community programs. This program will be targeted at patients that are at great risk of disconnect from the health care system.

**How does this project represent a new initiative or significantly enhances an existing delivery system reform initiative.**

Patient Navigators were introduced into the healthcare setting for patients that had been diagnosed with cancer as a way to help these patients deal with the complexities of their diagnosis and treatment options and with the goal of saving lives by ensuring barriers were eliminated and appropriate care was received timely. In that context, Patient Navigators have played a vital role in the lives of many cancer patients. Embracing that philosophy, Nix will embark on a new initiative of providing Patient Navigation Services to patients who are suffering from other chronic diseases that could also benefit from a personal “guide” to help them navigate through the maze of the health care system with the overall goal being to improve outcomes and patient satisfaction. This initiative, or related activities, is not being funded in whole or part by the U.S. Department of Health and Human Services.

**Related Category 3 Outcome Measure(s):**

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<thead>
<tr>
<th>OD-9 Right Care, Right Setting</th>
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<tbody>
<tr>
<td>IT-9.2 ED appropriate utilization (Standalone measure)</td>
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<tr>
<td>Reduce Emergency Department Visits for targeted conditions:</td>
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<tr>
<td>- Diabetes</td>
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</tbody>
</table>

**Reason/rationale for selecting these outcome measures:**

Through the Patient Navigator Program, patients will be aided in finding health care resources and providers for their needs, and they will be educated on the community resources that exist pertaining to their chronic diseases. Through this navigation assistance, patients will be less likely to need to present to the ED for treatment of their chronic diseases since these will be better managed on an outpatient basis proactively. Diabetes, in particular, is very prevalent in our patients and we expect to make a large impact with these patients through our Patient Navigator program.

**Relationship to other Projects:**

This project overlaps with our Medical Home Model Project and our Performance Improvement project for geriatric patients with respect to patients from either of those projects having the potential to be referred to the Patient Navigator Program.

Also, this project directly relates to several Category 4 projects:

• Potentially Preventable Admissions: By aligning the patients with resources to address
their chronic diseases, preventable admissions will be reduced.

- 30-Day Readmissions: During admission, if a patient is identified at high risk of readmission, they may be referred to the Patient Navigator program and post-discharge resources will be made available to the patient to reduce the likelihood or readmission within 30 days.

- Patient-centered healthcare: By addressing the full needs of the patient and working diligently to ensure that the patient’s needs are addressed, we are taking steps necessary to center health care around the patient

- Emergency Department: By assisting the patients with chronic conditions find help through other means besides the ED, the throughput in the ED will likely improve, and will benefit the patients in the ED and reduce the Admit-Decision time.

**Relationship to Other Performing Providers’ Projects in the RHP:**

Other performing providers are planning projects that will either Expand or Establish a Patient Navigation Program. As members of the RHP, we will work with these other providers to discuss our implementation initiatives, share best practices and new ideas, and work towards implementing solutions to identified problems.

**Plan for Learning Collaborative:**

TBD

**Project Valuation:**

The Patient Navigator Model, originally implemented for cancer patients, has proven invaluable as a way to help patients navigate through the health care system. Oftentimes patients need an advocate who understands the medical system and can help direct them to resources that they may otherwise be unaware of. The goal is to help and support patients in need of coordinated care navigate through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The Medical Home Model has incorporated the Patient Navigator into their model but we plan to take it a step further an off a Patient Navigator to patients of our health care system as a whole - a concierge of sorts. Someone who can assist patients in understanding each step on their road to recovery or help them better manage their chronic conditions.

The value of this coordinated effort is challenging to quantify since a large part of its value will be seen in the reduction of fragmentation and the improvement in patient satisfaction. However, for each patient that is enrolled into the Patient Navigator Program the value would be $1,200 per year minimum. Patients would be identified as being at the most risk by their PCP or attending physicians during an inpatient stay, and they would be enrolled in the Patient Navigation Program.

We anticipate that conservatively our provider-based primary care physicians cover nearly 30,000 patient lives and assuming 3% of the patients are referred to the Patient Navigator program each year, the value would be $1 M (0.03*30,000 = 900*$1,200 annually = $1,080,000). However, the referrals to the Patient Navigator Program would not be limited to only our Provider-Based PCPs. Patients identified through the ED or during inpatient admission
as being vulnerable or at high-risk could be referred to the program.

The $1,200 annual savings per enrollee is a conservative estimate taking into account reduced ED visits (estimated cost avoidance of $1,318\(^1\) per avoided ER visit), reduced admissions (estimated cost avoidance of $5,359\(^2\) per avoided admission), less fragmentation of care, and fewer life-years lost due to lack of access to care.

\(^1\)Agency for Healthcare Research and Quality Medical Expenditure Panel Survey: Emergency Room Services

\(^2\)Texas Health and Human Services Commission, Potentially Preventable Readmissions in the Texas Medicaid Population Fiscal Year 2010

NOTE – Through our estimation, this project could be valued as high as $1.5M per year, but in order to stay in line with our Pass 2 allocation, we have valued it at $1,075,916 in DY2, $1,175,566 in DY3, $1,183,167 in DY4 and $976,212 in DY5
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<th>2.9.1</th>
<th>2.9.1. A-E</th>
<th>2.9.1 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM</th>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-2] Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education</td>
<td><strong>Milestone 2</strong> [P-2] Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education</td>
<td><strong>Milestone 4</strong> [P-2] Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education</td>
<td><strong>Milestone 6</strong> [P-2] Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education</td>
</tr>
<tr>
<td>Metric 1 [P-2.1] Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators</td>
<td>Metric 2 [P-2.2] Number of unique patients enrolled in the patient navigation program provided.</td>
<td>Metric 4 [P-2.2] Number of unique patients enrolled in the patient navigation program provided.</td>
<td>Metric 6 [P-2.2] Number of unique patients enrolled in the patient navigation program provided.</td>
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<td>Milestone Estimated Incentive Payment: $488,106</td>
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<tr>
<td><strong>Milestone 3</strong></td>
<td><strong>[I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</strong>&lt;br&gt;Metric [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED&lt;br&gt;Baseline: No Patient Navigator Program exists, and ED is expected to open in late 2012&lt;br&gt;Goal: 50%&lt;br&gt;Data Source: ED/Patient Navigator Documentation</td>
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<td><strong>Milestone 5</strong></td>
<td><strong>[I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</strong>&lt;br&gt;Metric [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED&lt;br&gt;Baseline: No Patient Navigator Program exists, and ED is expected to open in late 2012&lt;br&gt;Goal: 60%&lt;br&gt;Data Source: ED/Patient Navigator Documentation</td>
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<td><strong>Milestone 7</strong></td>
<td><strong>[I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</strong>&lt;br&gt;Metric [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED&lt;br&gt;Baseline: No Patient Navigator Program exists, and ED is expected to open in late 2012&lt;br&gt;Goal: 70%&lt;br&gt;Data Source: ED/Patient Navigator Documentation</td>
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**Year 2 Estimated Milestone Bundle Amount: $1,075,916**  
**Year 3 Estimated Milestone Bundle Amount: $1,175,566**  
**Year 4 Estimated Milestone Bundle Amount: $1,183,167**  
**Year 5 Estimated Milestone Bundle Amount: $976,212**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,410,861**
Identifying Project and Provider Information:

Project: 2.12.1 Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions
Unique RHP ID#: 127294003.2.1 – PASS 1
Performing Provider: Peterson Regional Medical Center
Performing Provider TPI: 127294003

Project Summary:

Provider Description: Peterson Regional Medical Center (PRMC) is the only community healthcare organization within Kerr County and is located in the town of Kerrville. The population for Kerrville (2011) was listed as 22,423 and the population for Kerr County (2011) was 49,783. Kerr County is a total of 1,108 sq miles (45 persons/sq mile) with only 20.3 (1,100.7 persons/sq mile) of that belonging to Kerrville. PRMC provides healthcare and medical resources to nine surrounding counties with a total population of 187,293. Kerr County has been listed as a Healthcare Provider shortage area; this however is magnified by the fact that the majority of surrounding counties is also listed as shortage areas, and/or is unable to provide any healthcare services at all. It was found in our Community Health Needs Assessment held in October of this year that 28% of Kerr County’s population is unfunded, which is much higher than the national average of unfunded population which was found to be 16% and the national benchmark 11%. Of PRMC’s total diabetic population visits, Medicaid/Indigent/Self-pay comprised 11%.

Intervention(s): This project will utilize recommendations from several evidence base practice models to implement a new discharge and care transition process for the targeted population (Diabetic patients) at PRMC. A Registered Nurse acting as the Discharge Advocate (DA) will coordinate the patient’s discharge education tailored to meet the needs of each individual patient, arrange follow-up appointments with primary care providers and specialists, and post hospital discharge follow-up calls. The DA will promote a patient/family-centered environment that will encourage the patients and their family members/caregivers to participate more in their health care and treatment plans. The goal of this project is to use the DAs, hospital medical staff, and pharmacists to provide collaborative patient and family-centered care during transition. This will be accomplished by enhancing care coordination, community outreach, social support, education using appropriate level of health care literacy, and culturally competent care to diabetic patients. The DA will ensure adequate planning and arranging of discharge needs has occurred, as well as confirming patient and family understanding of disease specific self management care at home. The DAs will also be required to participate in outreach activities and collaboration with multi-disciplined stakeholders from all over the county and any outside of the county that will be willing to collaborate with our organization.

Need for the project: This project was chosen to address PRMC’s currently fragmented discharge process, 19% of total diabetic population visits at PRMC were seen in our ED, and rapidly increasing population growth rate of diabetes in Kerr County. Kerr County went from being ranked 196th (out of 254 Texas Counties) in 2011 to 246th in 2012 in the diabetes category. Given shorter lengths of stay in acute care, the clinical team is pressured to prepare patients to perform more complex self-management tasks that are often difficult at best for patients to understand.

Target population: One of the nation’s leading killers, diabetes is a costly, chronic disease that, if not diagnosed and treated properly, over the course of time can lead to serious complications such as heart disease, stroke, blindness, lower-limb amputation, kidney failure, disability, and premature death. As stated in the above paragraph, Kerr County went from being ranked 196th (out of 254 Texas Counties) in 2011 to 246th in 2012 in the diabetes category. If that alone wasn’t
ample enough of a reason to target this population in our community, the reality of how many of our community residents are unfunded/underfunded compounds the complexity of being able to care for these patients with any kind of magnitude or degree of quality value extremely difficult. It was found in our Community Health Needs Assessment held in October of this year that 28% of Kerr County’s population is unfunded, which is much higher than the national average of unfunded population which was found to be 16% and the national benchmark 11%.

Category 1 or 2 expected patient benefits: This project seeks improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies established in DY1-DY2. In DY4, we plan to improve percentage of the targeted population to reach 75%. In DY5, we anticipate meeting the discharge needs of 95% or more for this same group.

Category 3 outcomes: OD-9 Right Care, Right Setting IT-9.2 Reduce Emergency Department visits for target condition - Diabetes will be executed in DY4 and DY5. 19% of total diabetic population visits at PRMC were seen in our ED in calendar year 2012. DY4 improvement target is to reduce ED visits as a percentage of total diabetic population visits by 5%. DY5 improvement target is to reduce ED visits as a percentage of total diabetic population visits by 5% for a total of 10%.

Project Description:

Peterson Regional Medical Center proposes to improve the discharge planning and transitioning of care processes through applying an evidence-based best practice model for a targeted chronic disease population.

This project will implement a new discharge and care transition process. Recommendations of patient care guidelines were conquered from several evidence-based practice model sources. We have chosen to mirror the Project Re-Engineered Discharge (Project RED) model created by Boston University Medical Center. Founded on 11 discrete, mutually reinforcing components, Project RED has been proven to reduce rehospitalizations while also generating high rates of patient satisfaction. Components incorporate patient education, care coordination, primary care physician (PCP) prearranged follow-up, and telephone follow-up calls from both the Discharge Advocate (DA) and a Pharmacist. Improved patient understanding of discharge needs and timely follow-up care; we aim to decrease unnecessary emergency room usage and readmissions for patients of the targeted population. Chart reviews will be completed on all targeted patients readmitted to the hospital within 30-days, results from review will be utilized for process improvement activities.

A Registered Nurse will play the role of the DA. The DA will collaborate with other healthcare providers in caring for targeted population. These patients will also receive an ‘After-Hospital Care Plan’ folder. This folder will be tailored to meet the needs of each individual patient and their post hospital care and treatment plans. Information within the folder will be designed to clearly present the information patients need to prepare them for the days between discharge and the first visit with their PCP. The DA will oversee the discharge process to ensure relevant patient information has been entered into a dedicated, electronic program that will serve as the nexus of all information regarding patient discharge and follow-up care. The plan will contain information about the discharge diagnosis; a list of discharge medications, including why and when the patient needs to take each medication; a daily medication schedule that indicates visually what time medications should be taken; instructions about what the patient should do if his or her condition changes, including phone numbers of outpatient providers; a schedule indicating appointments with outpatient providers and/or follow-up tests;
information on diet, exercise, and home equipment; and information to enable the patient to take an active role in follow-up care.

Efforts will also be made to further prevent any medication related preventable patient harm by having a pharmacist call patients from this targeted group discharged using the RED process when appropriate. Pharmacist will review their medications, assess whether they are taking the medications as prescribed, determine whether they understand how and when to take them, verify the dosage and times of day the patient should take the medications, explain the potential for adverse events such as drug–drug or drug–food interactions, and intervene when necessary. Specific improvement targets are described in the table.

**Goals and Relationship to Regional Goals**

The goal of this project is to use Discharge Advocates, hospital medical staff, and pharmacists to provide collaborative patient and family centered care during transition. This will be accomplished by enhancing care coordination, community outreach, social support, education using appropriate level of health care literacy, and culturally competent care to diabetic patients. The DA will ensure adequate planning and arranging of discharge needs has occurred, as well as confirming patient and family understanding of disease specific self management care at home. Support will be given to these patients and their family members to navigate through the healthcare continuum in transition of care. By utilizing this DA as a transition specialist, the discharge process for the targeted group will increase patient safety and improve the quality of our discharge process.

**Project Goals:**

This project will not only meet the health need challenges of Kerr County but also hospital specific challenges such as a fragmented discharge process, unclear discharge instructions, staffing, and gap between healthcare providers during transition of care. Goals include:

- Creating a patient/family-centered environment that encourages participation in their health care and treatment plans; Improve the patients hospital and discharge experience
- Improve quality and safety of patient care; Promoting better health for beneficiaries
- Early collaboration with outside providers, especially for Medicaid, Indigent and Self-pay patients, to ensure all resources are arranged and post hospital needs are met
- Decrease the amount of wasted healthcare money and resources from readmissions and unnecessary Emergency Department visits caused by a lack of follow up, inability to obtain needed medications, etc.
- Implementing interventions that result in process improvements in medication management, post-discharge follow-up, communication and coordination of care
- Interacting with leaders and innovators in the field of Care Transitions during a statewide collaborative of providers sharing best practices
- Integration of an information system capable of securely and easily transfer important patient care and treatment documents to other healthcare providers across the continuum of care
- Encourage community collaboration with other agencies and influential leaders to meet the needs of our target population
- Increase patient understanding of post hospital care instructions, improve care transitions from hospital to home, and promote self-health management

**This Project Meets the Following Regional Goals:**

- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties; Improve outcomes while containing cost growth
- Further develop and maintain a coordinated care delivery system

Thus we expect to see improved patient satisfaction, better health outcomes, reduced healthcare cost, decreased readmissions, and prevent unnecessary emergency department use within the defined disease specific population group.

**Challenges**

Current challenges discovered in our Community Health Needs Assessment found that Kerr County has a much older population than the average for both Texas and United States. This older population is going to generate a higher demand for healthcare services. With Type II Diabetes being directly related to obesity, another challenge PRMC will face is that obesity is considered the top problem Kerr County faces (as reported by Stratasan in County Health Needs Assessment).

To address these challenges an action plan will be implemented to ensure all are considered during creation of Project RED’s policies and procedures that will include a comprehensive and reliable discharge plan that will help to reduce readmission rates plus unnecessary Emergency Department visits, improve health outcomes, and ensure quality transitions. A template for disease specific discharge education material will be created using appropriate literacy level for targeted population, which will allow for adjustments as needed. Information gained while collaborating with other stakeholders whom have had previous experience with making this type of process change will also be considered. Once policies have been approved, the positions will be opened up to those interested in applying, qualified applicants will be hired to fill role of the DA. Outreach and collaboration with multi-disciplined stakeholders from across the county will be of great importance over the next four years.

Diabetes is one chronic condition whose treatment and outcomes are heavily dependent on how well the patient monitors and manages the disease outside the health care setting. An important approach to quality improvement for diabetes is improving patient self-management. This project will include components of a diabetic specific ‘Self-management program’. The DA along with other Health care professionals will work with patients to build their confidence in managing their own disease, in working within the health care system and the community to have their needs met, and in managing the emotional effects of their illness. Patients are informed about their disease and trained using evidence-based information in how they should manage their condition.

**5-Year Expected Outcome for Provider and Patients:**

PRMC expects to see improvements in safety, quality of care and health care outcomes of diabetic patients that participate in the innovative discharge process. PRMC expects to see improve in the patient’s ability to maintain self management at home in their own environment and when/where they should seek care if conditions change; providers encouraging patient and family involvement in their care; a standardized discharge process that is closing the gaps during transition and preventing potential adverse outcomes, and/or patients falling through the cracks being forgotten about and never followed back up with. Expected outcomes will relate to the projects goals described above.
Starting Point/Baseline:

Currently there are no clients/patients served by the proposed project or any of the included process/improvement milestone interventions. At this current time, we also do not have any providers trained in this area/project. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2. PRMCs baseline diabetic population in calendar year 2012 is a total of 3,719 patients with 12% or 1,226 visits having an inpatient stay.

Rationale:

Option 2.12.1 was chosen to address currently fragmented discharge process, increased unnecessary ED visits within the high risk diabetic population group, and increasing population growth rate of diabetes in Kerr County. When a patient’s transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. Expectations for self-care health management after hospitalization are becoming more challenging for patients. Given shorter length of stay in acute care, the clinical team is pressured to prepare patients to perform more complex self-management tasks that are often difficult at best for patients to understand. Therefore, it makes sense to develop a discharge process to efficiently and reliably provide a patient with the tools and understanding to comply with their healthcare needs.

Residents of rural counties tend to be older and less educated, experience lower per capita income and more poverty than the region as a whole, further compounding the healthcare challenges faced here (Stratasan, 2012). Kerr County has a much older population than the average for other counties across Texas. This alone generates a much higher demand for money spent on healthcare services (Stratasan, 2012). Inpatient services are being utilized more in Kerr County than any other county in Texas, while outpatient services are utilized less than the average utilized across the state of Texas (Stratasan, 2012). Kerr County provides clinical care to 28% of the population that are uninsured. The Texas average of uninsured population is 26% and the National Benchmark is 11% (Stratasan, 2012). Peterson Regional Medical Center alone provides on average $2 million a month in charity care to help meet the medical needs for this population.

One of the Nation’s leading killers, diabetes is a costly, chronic disease that, if not diagnosed and treated properly, over the course of time can lead to serious complications such as heart disease, stroke, blindness, lower-limb amputation, kidney failure, disability, and premature death. Texas ranks 34th of 50 states with 9.7% of the population suffering from diabetes, the national average is only 8.7% (Americas Health Rankings, 2011). Kerr county went from being ranked 196th (out of 254 Texas counties) in 2011 to 246th in 2012 in the diabetes category (County Health Rankings, 2012).

Project Components

Through the Discharge and Transition of Care Program, we propose to meet all required project components.

a) Review best practices from a range of models – Components from each RED, BOOST, and STAAR discharge and transition of care program will all be referred to during the planning stages. The DA will be trained to use components from each model. Implementation of evidence based elements within models will outline a safe discharge plan and supporting transitions of care which will help achieve improved patient satisfaction, patient outcomes,
decreased overall healthcare cost and reduced preventable readmissions.

b) **Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool** – The Care Coordination Department collects this readmission data during their assessment of the patient and their discharge needs and documents it within the organizations EMR. Meaningful data cannot currently be extracted at this time. In order for this information to be reported in a useful format PRMC will need to contract with an outside resource.

c) **Integrate information systems so that continuity of care for patients is enabled** – In the attempt to ensure a smooth transfer of data from provider-to-provider, and agency-to-agency a request has been made for a new software package. This software is the same that Home Health, Hospice, most of the PCPs in the community use, as well as each of the Nursing Homes. It is fully integrated; web-based solutions that simplify and consolidate utilization management, discharge planning, and outpatient care management, documentation integrity, quality management and risk management.

d) **Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 day** – All patients in the diabetic targeted population group will receive the discharge planning and transition of care process as implemented. PRMC will identify and collect data on all patients with diabetes as a primary diagnosis or co-complication. From this overall population group we will further separate data for patients with a payer source of Medicaid, Indigent and Self-pay. Adjustments to their discharge education and arrangements by the DA will be made as determined during patient assessment. Each of these targeted patients will also receive follow-up from several sources even after they are discharged, such as: the follow-up phone call from the DA, the follow-up phone call and medication education from the pharmacist, and the follow-up appointments and frequent communication from/with the Chronic Disease Management Nurse. All patients will be scheduled their follow-up appointment with their PCPs and any other specialists with-in 3-7 days after discharge. If it is still felt that the patient will need some additional follow-up from a medical provider, home health will be arranged to check in on patient the days that they are not being followed up with from any of the providers mentioned above.

e) **Implement discharge planning program and post discharge support program** – The DA will make their first contact with the targeted patient population within 24 hours after admission. Over the course of the patients stay, they will meet with the DA multiple times to discuss and plan for the patient’s discharge. The DA will also attend our daily multi-disciplinary meetings (which also includes all hospitalists) for further discussion of discharge needs with the rest of the medical team. During their orientation, the DA(s) will be introduced to outside community agencies and local community leaders. It will be important for them to start networking early to create these bonds with the people/agencies that will be assuming care of the patient once discharged home. When program is up and fully running the DA will continue to keep in close contact with these community providers and advocate for any additional patient needs as needed.

f) **Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers** – The Care Coordination Department currently holds quarterly collaboration meetings with the local Nursing Home Administrators. These meetings have created a partnership between these two groups and successfully improve patient care, safety, quality, and
transition of care. With the commencement of this new program, additional members will be invited to the meetings. New members will include administrators from the local home health and hospice agencies, as well as the practice managers from local primary care practices.

g) **Conduct quality improvement for project using methods such as rapid cycle improvement.** Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. **Including special considerations for safety-net populations** - Collaborative self-management support (CSMS) means that everyone works together to help the patients manage their condition. CSMS is centered on the patient’s specific needs, abilities, values, and preferences. Families and others in their support network are welcomed to participate.

To maintain healthy lives, people with chronic or long-term conditions and their families have to manage their condition from day to day. Self-management often involves medical treatments and therapies. It can also mean making lifestyle changes, such as eating better, reducing stress, or increasing exercise. This care planning process is done together in a patient-centered environment.

**The unique community need identification numbers the project addresses are:**

- CN.1 - Deliver improved quality and patient satisfaction.
- CN.2 - Greater prevention efforts and improved management of patients with chronic conditions
- CN.3 - Access to medical care for patients regardless of payment status

**How the project represents a new initiative or enhances an existing delivery system reform initiative**

The project is not currently being used in clinical practice. All components (milestones and metrics) of this project represent new initiatives for the performing provider. It was also discovered that recently Project RED has lost their funding from AHRQ, which was caused by government budget cuts.

**Related Category 3 Outcome Measure(s):**

OD-9 Right Care, Right Setting and IT 9.2 was chosen as the projects outcome domain based on 19% of overall diabetic population visits were Emergency Department setting. High volumes of diabetic patients using the Emergency Department as their primary source of care increases health care cost and fragments continuity of care which should be provided in less costly settings. Proper implementation of Category 2 process improvements within the diabetic population group will improve transition of care resulting in an expected decrease in emergency department visits by 5% in DY4 and an additional 5% in DY5.

Recent studies evaluating hospital discharges have associated the risk of adverse events with deficiencies in health literacy, patient education, communication among health care providers within and between sites of care, appropriate medical follow-up, and any number of issues related to medications; all which also affect patient safety during transition of care. Components of the project will center attention on cost effective affordable care to include and not limited to post hospital follow-up, medications, supplies, and receiving the right care in the right setting at the right time.

**Relationship to other Projects:**

For Pass 1, PRMC was only required to complete one project for Category 1 and 2. Related Category 4 measures include Population-focused measures: RD-1.2 Potentially
Preventable Admissions - Diabetes Admission Rates; RD-2.2 Diabetes 30 Day Readmissions; RD-3 Potentially Preventable Complications; RD-4.1 Patient-centered Healthcare - Patient Satisfaction and Medication management; and RD-5 Emergency Department

**Relationship to Other Performing Providers’ Projects in the RHP:**

From the “draft” list provided, providers in the RHP that are establishing programs similar to ours are:

- UTHSCSA 2.2 Expand Chronic Care Management Models, and 2.4 Redesign to Improve Patient Experience
- University Health System 2.2 Expand Chronic Care Management Models, and 2.4 Redesign to Improve Patient Experience
- Methodist 2.4 Redesign to Improve Patient Experience
- Methodist 2.4 Redesign to Improve Patient Experience
- Bluebonnet 2.9 Establish/Expand Patient Navigation Program

**Plan for Learning Collaborative:**

University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives. Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following: Identify participants; Establish Learning Collaborative goals; Develop a calendar of regular meetings, site visits, and/or conference calls; Develop a plan to communicate ideas, data, and successes across the region and state; Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices; Adopt metrics to measure success.
**Project Valuation:**

Peterson Regional Medical Center is licensed for 125 acute care beds. The diabetic population in calendar year 2012 consisted of 3,719 patients. 11% of the visits were provided for the Medicaid/Indigent/Self-pay subpopulation. The implementation cost of this project for DY1-DY2 is estimated to be $434,292. Each year thereafter has an estimated cost of $267,272. In calendar year 2012 PRMC’s baseline diabetic population group had a total of 3,719 patients with 1,226 inpatient admissions for a total of $28.8 million in charges. Once project outcomes have been reached, we estimate an average annual community healthcare savings of $2.9 million by reducing the rate of inpatient admissions (as a percentage of the total diabetic population) by 10%. Currently, PRMC has 0 patients receiving standardized care processes related to project RED. In DY2 we will begin implementation of program for focused patient population and initial patients receiving standardized care processes related. In DY4 we will improve the % of patients in defined population receiving standardized care according to Policy & Procedure by 75% and to 95% in DY5.

This project will address many of the discovered community health care needs by strategically implementing components of an evidence-based care transition model. Project Re-engineered Discharge (Project RED) began at Boston University Medical Center and was designed to improve the hospital discharge process in a way that promotes patient safety and reduce re-hospitalizations. The Project Red model is supported by the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).

This model will be used to assist in closing the gap in health care services of Kerr County residents causing them to utilize more costly inpatient services versus less costly outpatient services. The shortage of primary care physicians in Kerr County has contributed to an increase use of ED visits often resulting in inpatient services. Patients with chronic diseases who are not established with a primary care provider are more likely to show up in the emergency department in crisis, which often results in an inpatient admission. The components of Project Red will prepare patients to better understand their disease process and address individual needs enabling them to better care for themselves. After a patient has been admitted to the hospital they are usually motivated to learn more about their illness; it is crucial that healthcare providers take advantage of this opportunity to educate and coordinate care during and beyond the hospital setting. This will allow patients to feel more involved and increase potential compliance with their own healthcare needs. By utilizing a more patient-centered discharge model patients will experience more buy in to improve and maintain their own health at home.
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<tr>
<th>127294003.2.1 PASS 1</th>
<th>2.12.1</th>
<th>2.12.1.A-G</th>
<th>2.12.1 Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions</th>
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<tr>
<td><strong>Peterson Regional Medical Center</strong></td>
<td><strong>TPI - 127294003</strong></td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>127294003.3.1</td>
<td>3.IT-9.2</td>
<td>IT-9.2 Reduce Emergency Department visits for target condition - Diabetes (Standalone)</td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 1</strong> [P-1]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions</td>
<td><strong>Milestone 2</strong> [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program</td>
<td><strong>Milestone 3</strong> [P-2]: Implement standardized care transition processes</td>
<td><strong>Milestone 4</strong> [P-3]: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge</td>
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<td>Metric 1 [P-1.1]: Care transitions protocols Baseline: No protocols in place Goal: Development and submission of evidence-based protocols for Project RED program Data Source: NIH, AHRQ, HCPro, Texas Hospital Quality, IOM, IHI, PCORI</td>
<td>Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline: No staffing or implementation plan Goal: By the end of DY3 we will complete a staffing and implementation plan Data Source: Staffing and implementation plan Milestone 2 Estimated Incentive Payment: $848,428</td>
<td>Milestone 3 Estimated Incentive Payment: $567,263</td>
<td>Milestone 4 Estimated Incentive Payment: $567,263</td>
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<td>Milestone 5 [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies</td>
<td>Milestone 6 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: Improve the % of diabetic patients in defined population receiving standardized care according to P&amp;P established in DY2 to 95% Data Source: Meditech report/analysis</td>
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<td>Milestone 7 [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies</td>
<td><strong>Milestone 8</strong> [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: Improve the % of diabetic patients in defined population receiving standardized care according to P&amp;P established in DY2 to 95% Data Source: Meditech report/analysis</td>
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<tr>
<td>Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines</td>
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**Goal:** Improve the % of patients in defined population receiving standardized care according to P&P established in DY2 to 75%

**Numerator:** Number of diabetic inpatients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.

**Denominator:** Number of diabetic patients discharged

**Data Source:** Meditech report/analysis

**Baseline:** 3.3% of diabetic population is defined as high ED users in calendar year 2012 with 4 or more visits per year. This group accounts for 18% of total diabetic population ED visits or an avg. of 5x the usage rate of other diabetic patients.

**Goal:** Reduce the % of high
<table>
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<th>Year 2 Estimated Milestone Bundle Amount: $1,555,399</th>
<th>Year 3 Estimated Milestone Bundle Amount: $1,696,856</th>
<th>Year 4 Estimated Milestone Bundle Amount: $1,701,789</th>
<th>Year 5 Estimated Milestone Bundle Amount: $1,405,826</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,359,870
Identifying Project and Provider Information:

Title: 2.6.4 Implement Evidence-based Health Promotion Program: Develop, implement, and evaluate an innovative evidence based health promotion strategy through the use of a mobile cardiovascular screening program.
Unique RHP ID#: 136491104.2.1 – PASS 1
Provider Name: Southwest General Hospital
TPI: 136491104

Project Summary:

Provider Description:
Southwest General Hospital is a 327-bed, acute care hospital in San Antonio, Texas serving residents of RHP 6 and surrounding areas. RHP 6 encompasses 20 counties and covers 24,734 square miles, comprising about 9.5% of the total land area of Texas.

Intervention(s):
The project encompasses the development, implementation, and evaluation of an evidence based health promotion strategy through the use of a mobile cardiovascular screening program for RHP 6 and surrounding rural community residents.

Need for the project:

- Currently at Southwest General Hospital, 45% of patients are Medicaid recipients or uninsured. The Mobile Cardiovascular Screening Program will assist with improving the early identification of cardiovascular health issues and the care delivery infrastructure to better serve the Medicaid and uninsured residents of South San Antonio and surrounding rural communities.
- Cardiovascular disease is one of the leading causes of death in RHP 6. Early disease identification, intervention and management are critical to reduce this potentially preventable disease.
- RHP 6 has a higher percentage of patients who are unable to access primary care due to the high cost, as compared to the Texas average from 2007-2010. Access to affordable care has been an issue within the region, leading to poor health outcomes and a high percentage of preventable hospitalizations.
- Healthcare impact of a major oil/gas play in a rural environment. Oil and gas business in South Texas to include South San Antonio, Atascosa, and Wilson counties, have presented a new, large population to the RHP 6 region. A large pool of uninsured workers will impact the numbers in need of cardiovascular screening. Excluding the oil and gas employees, 24% or 471,000 residents of RHP currently lack health insurance coverage. Small firms in rural areas cannot afford to insure employees or most are self employed. The potential numbers for cardiovascular screening is difficult to project based on the rapid population growth in the Eagle Ford Shale region of RHP 6. The shale activity is projected to create nearly 117,000 full time jobs by 2021.
- Nearly every county in RHP 6 is designated as a Health Provider Shortage Area for primary care.

Target population:
The target population is RHP 6 rural community residents with the focus on Medicaid and uninsured residents of South San Antonio and rural communities with unsuspected or
undiagnosed cardiovascular disease. As stated above, the rapidly increasing population of this area impacts the ability to project numbers benefitting from the screening project.

**Category 1 or 2 expected patient benefits:**
- Early identification of potential and/or actual cardiovascular disease processes requiring medical or surgical intervention.

**Category 3 outcomes:**
- Reduction of emergency department visits of targeted population by 5% from year 3 to year 4.
- Reduction of emergency department visits of targeted population by 7% from year 4 to year 5.
- Adequate blood pressure control demonstrated by 5% of patients on follow-up visits from year 3 to year 4.
- Adequate blood pressure control demonstrated by 7% of patients on follow-up visits from year 4 to year 5.

**Project Description:**
Southwest General Hospital proposes to implement an innovative evidence based health promotion strategy through the development, implementation, and evaluation of a mobile cardiovascular screening program.

Through the implementation of a mobile cardiovascular screening program, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. The program will provide a mobile vascular screening service which will provide non-invasive screenings. Tests will be performed by vascular technologists with results and a follow-up plan, as necessary, provided at the time of screening.

Through the goal of improving cardiovascular health for the residents of RHP6 through a mobile screening program, the project will impact the following:

- Enhance availability of resources to assess and refer residents of rural communities for cardiovascular healthcare resulting from mobile screening assessment
- Establish referrals to cardiovascular specialists within the Southwest General physician community to provide specialty care to high risk residents
- Quality improvement efforts will focus on use of rapid cycle improvement methodologies to identify and quickly address project barriers and/or implementation barriers which would include the impact of marketing strategies on reaching target communities which will direct ongoing plan revisions and/or target market. CQI activities will also include weekly team huddles to identify areas of strength and weakness related to screening program operations and immediate revisions as necessary.

**Goals and Relationship to Regional Goals:**
The goal of this project to develop and implement innovative, evidence based screening program to identify high risk patients in need of specialty care services (Cardiovascular) and to provide
care for high risk cardiovascular problems identified by outreach vascular screening programs to RHP 6 rural communities.

**Project Goals:**

- Develop, implement, and evaluate a mobile Cardiovascular Screening Program for the RHP 6 region
- Increase access to care for RHP 6 rural community residents to identify potential and/or actual cardiovascular disease processes requiring medical or surgical intervention

**This program meets the following regional goals:**

- The Mobile Cardiovascular Screening Program will contribute to assuring patients receive high-quality, patient centered care with the goal of early disease identification and intervention for cardiovascular problems through improved access to care provided by the Mobile Cardiovascular Screening Program.
- The Cardiovascular Screening Program will assist with improving the health care delivery infrastructure to better serve the Medicaid and uninsured residents of South San Antonio and surrounding rural communities. Currently at Southwest General Hospital, 45% of patients are Medicaid recipients or uninsured.
- The program will build on the existing cardiovascular specialty service which is comprised of private and 501a employed cardiologists. Outreach efforts will serve to identify and reach key rural areas currently experiencing difficulty with access to care.

**Challenges/Issues Faced By Provider:**

- Identifying vendor most capable and compatible with existing resources – Southwest General Hospital currently contracts with a company for vascular ultrasound services. The contract will be reviewed to include the Cardiovascular Screening program in the services provided to SWG. In collaboration with this company the hospital will, in the near future, be evaluated for ICAVL accreditation. Also, an additional Cardiovascular Technologists will be hired to assist with program management.
- Vascular Technologist support – Through existing contracted vendor will negotiate for additional technologist support
- Cardiovascular specialist follow-up commitment – SWGH has a total of eight active Cardiologists working to improve the Cardiology program at the hospital. The physicians will serve as the referring physicians for the program.
- Identification of evidence based programs to serve as a model for mobile screening program development and implementation – AHRQ Clinical Practice Guidelines for Cardiovascular Screening will serve as the foundation of best practice for program development and screening guidelines. They will include the following guidelines: Atherosclerotic cardiovascular disease screening in adults: American College of Preventive Medicine position statement on preventive practice (Lim, 2011) and Screening for coronary heart disease with electrocardiography: U.S. (Preventive Services Task Force recommendation statement, 2012).

**Source:**


5-year Expected Outcome:

Early identification and management of potential life threatening cardiovascular conditions (Stroke; Carotid Artery Disease; Peripheral Vascular Insufficiency, as well as access for services and treatment otherwise not available.

Starting Point/Baseline:

Currently, a mobile cardiovascular screening program does not exist for patients at Southwest General Hospital. Therefore, the baseline for the number of RHP 6 residents eligible for screening at 0 for DY2.

The Cardiovascular Center at Southwest General Hospital has provided cardiovascular and peripheral vascular care to the South San Antonio area and surrounding communities with excellent outcomes. We have the ability and knowledge to provide outlying communities through early identification and referral to appropriate resources needed to manage Cardiovascular dysfunction identified through community screening.

The ability to establish mobile outreach screening programs served by cardiovascular specialty staff in key rural areas will provide improved access to care, and specialist management of cardiovascular diagnosis and symptoms, as required. Cardiovascular disease is one of the leading causes of death in RHP 6. Early disease identification and management is critical to reduce this potentially preventable disease. Early identification and intervention is a desired outcome of the proposed initiative. Through the implementation of a mobile screening strategy, it is projected the screening encounters will increase by 10% from Year 4 to Year 5 through expansion of rural counties in which screening program is provided.

Rationale:

RHP 6 has a higher percentage of patients who are unable to access primary care due to the high cost, as compared to the Texas average from 2007-2010. Access to affordable care has been an issue within the region, leading to poor health outcomes and a high percentage of preventable hospitalizations.

According to the Agency for Healthcare Research Quality’s 2011 report, Texas ranks last in the nation on health care quality. The report is based on 155 quality measures which include disease prevention measures. Texas scored weak on preventive measures and under the category of “care by clinical area, Texas scored weak on heart disease measures. The shortage of health care
providers has led to high emergency room utilization. This is a very costly means of health care delivery, and often results in a delay seeking treatment until the illness is severe and advanced. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population’s health.

This issue will only continue as the population increases at its current rate. Improving identification and early intervention of cardiovascular problems will decrease misuse of the ED and lower healthcare costs. Across the state of Texas, ED visits increased by 28.6% with RHP 6 following this trend.

Cardiovascular disease is one of the leading causes of death in RHP 6. Early disease identification and management is critical to reduce this potentially preventable disease. Early identification and intervention is a desired outcome of the proposed initiative.

RHP 6 encompasses 20 counties and covers 24,734 square miles, compromising about 9.5% of the total land area of Texas. In some areas, it may take patients hours to drive to Performing Provider facilities. Therefore, a mobile cardiovascular screening clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively. Establishing a mechanism for timely, affordable care would lead to improved outcomes and would provide patients with education on how to manage their condition.

**Unique community need identification number the project addresses:**

- **CN.1** - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction
- **CN-2** – A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease.

As stated previously, the Cardiovascular Center at Southwest General Hospital has provided cardiovascular and peripheral vascular care to the South San Antonio area and surrounding communities with excellent outcomes. We have the knowledge and ability to provide outlying communities screening, early problem identification, and referral to appropriate resources to manage Cardiovascular dysfunction. Outcomes of the intervention will improve the care of residents and decrease the use of the Emergency Department for the first “screening” assessment for disease.

2 RHP 6 Community Needs Assessment, July 2012.
3 RHP 6 Community Needs Assessment, July 2012.
4 RHP 6 Community Needs Assessment, July 2012.
5 RHP 6 Community Needs Assessment, July 2012.
6 RHP 6 Community Needs Assessment, July 2012.
7 RHP 6 Community Needs Assessment, July 2012.

**Related Category 3 Outcome Measure(s):**

**Proposed Category 3 Outcome Measures:**
IT 9.2 - ED appropriate utilization
Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension

The shortage of health care providers and the identification of early disease processes have led to high emergency room utilization. This is a very costly means of health care delivery, and often results in a delay seeking treatment until the illness is severe and advanced. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population’s health. Through the development of a mobile cardiovascular screening program by Southwest General Hospital, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. Results and follow-up plan, as necessary, are to be provided at the time of screening. The proposed outcome of this project is early identification and referral of positive findings to a Cardiovascular specialist prior to acute manifestation of a clinical problem. The end measureable outcome being the decrease ED utilization for Cardiovascular symptoms due to early identification and management of potential life threatening cardiovascular conditions.

RHP 6 Community Needs Assessment, July 2012.

Relationship to other Projects:
A mobile cardiovascular screening program focused on health promotion, screening and access to disease management specialists would:

- 1.9: Expand our specialty care capacity along with several other initiatives pertinent to the RHP. The mobile unit would identify patients in need of further follow up with a specialty clinic.

The project aligns with Category 4 Population focused measures which are the following: RD-1 Potentially Preventable Admissions related to Congestive Heart Failure and Hypertension admission rate; and RD0-3 Potentially Preventable complications.

Relationship to Other Performing Providers’ Projects in the RHP:
Potential members of learning collaborative based on early review and identification of projects. Further detail required to assess comparability and potential for collaboration.

- CHRISTUS Santa Rosa Hospital – Implement Evidence based Health Promotion Programs; and Expand Specialty Care Capacity
- University Hospital; Baptist Medical Center; CHRISTUS Hospital of San Antonio; Methodist Hospital; Dimmitt County Memorial Hospital; Val Verde Regional Medical Center; and Connally Memorial Medical Center – Expand Specialty Care Capacity
- University Hospital; Hill Country Memorial Hospital – Implement evidence based disease prevention programs
**Plan for Learning Collaborative:**

At this time, without further background information and detail on projects for RHP 6, a plan for participation in a RHP-wide learning collaborative with other similar projects is not possible. The potential for collaboration with above identified projects and providers is critical to best practice identification and performance improvement projects.

<table>
<thead>
<tr>
<th>Project Valuation:</th>
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<tr>
<td>• Achieve Waiver Goals: Waiver goals include increasing 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. In support of the goal, Southwest General Hospital will develop a mobile program dedicated to vascular screening. Through this service the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. The program will provide a mobile vascular screening service which will provide non-invasive screenings. Tests will be performed by vascular technologists. Results and follow-up plan, as necessary, provided at the time of screening.</td>
</tr>
<tr>
<td>• Addresses Community Needs: As previously stated, early identification and management of potential life threatening cardiovascular conditions (Stroke; Carotid Artery Disease: Peripheral Vascular Insufficiency, as well as access for services and treatment otherwise not available is critical to meeting the healthcare needs of RHP 6. The shortage of health care providers has led to high emergency room utilization. This is a very costly means of health care delivery, and often results in a delay seeking treatment until the illness is severe and advanced⁹. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population’s health. Through the development of a Mobile Screening Program by Southwest General Hospital, dedicated to vascular screening, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner.</td>
</tr>
<tr>
<td>• Project Scope: Southwest General Hospital has provided care to the residents of South San Antonio since 1978. In late 2012, the organization achieved Chest Pain Accreditation and currently is preparing for PCI Accreditation with the Center. The expansion of the program to outlying communities will further enhance care but also extend high quality preventive care and education for the region. The program framework for cardiovascular services is developed and supports acute care needs for the area. Program development requires the expansion and planning to serve and identify a larger patient base and establish outreach programs to impact care for the patient population. Through the development of a mobile cardiovascular screening program by Southwest General Hospital, the surrounding rural communities will have the opportunity to access a vital health</td>
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</table>

"Southwest General Hospital"
resource to identify potentially serious cardiovascular events in a timely and cost effective manner.

- **Project Investment:**
  Many of the resources required to support the physician component of the proposed project is in place. The need to recruit and hire midlevel care providers is a key investment in manpower to support the endeavor. The purchase of additional noninvasive diagnostic equipment and a van to support the program will be a $190,000 investment by Southwest General Hospital to launch the program for its current patient population and the RHP 6 proposed project.

RHP 6 Community Needs Assessment, July 2012.
<table>
<thead>
<tr>
<th>136491104.2.1 PASS 1</th>
<th>2.6.4</th>
<th>N/A</th>
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<tbody>
<tr>
<td><strong>2.6.4 Implement an innovative, evidence based health promotion strategy through the development, implementation and evaluation of a mobile cardiovascular screening program.</strong></td>
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Southwest General Hospital | TPI - 136491104 |

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<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>136491104.3.2</th>
<th>3.IT-9.2</th>
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<tbody>
<tr>
<td><strong>Reduce Emergency department visits for target conditions: Congestive Heart Failure and Cardiovascular Disease/Hypertension</strong></td>
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<thead>
<tr>
<th>Year 2 <em>(10/1/2012 – 9/30/2013)</em></th>
<th>Year 3 <em>(10/1/2013 – 9/30/2014)</em></th>
<th>Year 4 <em>(10/1/2014 – 9/30/2015)</em></th>
<th>Year 5 <em>(10/1/2015 – 9/30/2016)</em></th>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
<td><strong>Milestone 5</strong></td>
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<tr>
<td>P-1 Conduct an assessment of health screening programs at the local and regional level for best practice programs. Goal: Program development based on evidence and best practice</td>
<td>P – 3 Implement, document, and test an evidence-based innovative cardiovascular screening program for RHP 6 region targeted population P-3.1. Metric: Document implementation strategy and testing outcomes. a. Data Source: Documentation of implementation results to included strengths, opportunities, volume screened, and number of referrals b. Rationale/Evidence: The importance of this milestone is to identify, support and compliment already existing resources in the community for health promotion programs.</td>
<td>I-6. a. Describe the participation of identified population in Cardiovascular Screening program: Identify percent of patients in defined population receiving mobile cardiovascular screening with evidence-based model. b. Identify percent of patients in population with positive screens from participation in mobile cardiovascular screening program with evidence-based model.</td>
<td>I-8. Increase access to mobile cardiovascular screening program through expansion of program offering to additional rural counties.</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment</strong></td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment</strong></td>
<td><strong>Milestone 5 Estimated Incentive Payment</strong></td>
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<tr>
<td>$257,564.50</td>
<td>$561,979</td>
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**Milestone 5**: I-8. Increase access to mobile cardiovascular screening program through expansion of program offering to additional rural counties.

I-8.1. Metric: Increase percentage of target population reached. Baseline: Increase percentage of target population reached by 10% from Year 4
a. Numerator: Number of individuals of target population reached by the provision of Mobile Cardiovascular Screening project.
b. Denominator: Number of individuals in the target population.
c. Data Source: Documentation of target population reached.
d. Rationale/Evidence: This metric speaks to the efficacy of...
| **Milestone 2** | **P-2 Development of evidence-based mobile cardiovascular screening project for RHP 6 targeted areas based on needs assessment and identified priorities of RHP6 community needs assessment.** |
|**P-2.1. Metric: Document strategy and plan.** | a. **Data Source:** Performing Provider evidence of plan.  
b. **Rationale/Evidence:** Documentation of innovational strategy and plan.  |
| **Milestone 2 Estimated Incentive Payment** | **$257,564.50** |

(South San Antonio counties) who are uninsured or receiving Medicaid.  

| **a. Numerator:** Number of individuals of target population reached by the provision of Mobile Cardiovascular Screening project.  
| **b. Denominator:** Total number of patients in defined population (RHP 6 region screened).  
| **c. Data Source:** Patient records  
| **d. Rationale/Evidence:** To test innovative screening model variables.  

This metric speaks to the efficacy of the project in reaching its targeted population.  

| Milestone 5 Estimated Incentive Payment: | **$465,593** |

| Year 2 Estimated Milestone Bundle Amount: | **$515,129** |
| Year 3 Estimated Milestone Bundle Amount: | **$561,979** |
| Year 4 Estimated Milestone Bundle Amount: | **$563,612** |
| Year 5 Estimated Milestone Bundle Amount: | **$465,593** |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** **$2,106,313**
**Identifying Project and Provider Information:**

Title: 2.7.6 – Implement other evidence-based prevention program in an innovative manner: TB prevention program  
Unique RHP ID#: 133257904.2.1 – PASS 1  
Performing Provider: Texas Center for Infectious Disease  
Performing Provider TPI: 133257904

**Project Summary:**

Provider Description: The Texas Center for Infectious Disease (TCID; 133257904) is a 75 bed facility that is currently the only inpatient facility dedicated to tuberculosis (TB) care in the U.S. TCID hospitalizes the most complicated and challenging TB patients in TX.

Intervention(s): This project will: a) increase targeted testing for latent tuberculosis infection (LTBI) in high risk minority communities, b) provide routine testing for LTBI with interferon gamma release assays (IGRAs) instead of tuberculin skin testing to minimize false positive tests in BCG vaccinated patients and avoid unnecessary LTBI therapy, c) provide routine treatment of LTBI through a 12 dose, 12 week regimen administered by DOT to improve patient adherence and completion of LTBI therapy, d) facilitate hospitalization for TB care of those few patients who cannot be successfully treated as outpatients.

Need for the project: TB continues to be a significant and expensive public health problem in TX. This project represents collaboration between three entities, TCID, University of Texas Health Science Center, Tyler (UTHSCT) and TX Department of State Health Services (DSHS), with renowned physician expertise that will deliver improved TB care for minority populations. The project includes targeted testing for LTBI, effective treatment of LTBI in order to prevent future cases, and case identification with referral for appropriate therapy (inpatient or outpatient). The project will be implemented in two public health regions of Texas, one urban and one rural in order to capitalize both on the expertise of providers and also to demonstrate a model of case identification and treatment delivery that is effective in reducing the spread of the disease while providing better health outcomes with improved patient satisfaction.

Target population: In 2011 in Public Health Regions 4 & 5N and 8, 1310 individuals underwent testing for LTBI including 833 as part of contact investigations which in the context of limited resources take priority over other recommended indications for LTBI testing. Only 573 received therapy with approximately 67% completing LTBI therapy. 178 patients were diagnosed with active TB with approximately 80% completing therapy. Economically disadvantaged minority populations suffer disproportionately from LTBI and active TB. Shorter, effective new LTBI treatment regimens are available however, not implemented broadly enough at this time to reduce the spread of the disease. People who do not have access to primary care services are the least likely to be diagnosed with LTBI and therefore, present a risk of developing and then spreading TB.

Category 1 or 2 expected patient benefits: Evidence-based CDC and DSHS treatment guidelines insure avoidance of unnecessary and costly diagnostic and treatment strategies while the application of new diagnostic (IGRA testing) and treatment strategies (12 week LTBI therapy) further reduce costs by focusing resources on interventions of proven public health value at a lower financial cost. This project will provide, a) enhanced access to a comprehensive fully integrated TB care process that utilizes the existing DSHS public health infrastructure and physician expertise from UT, b) implementation of universal LTBI testing with IGRAs thereby limiting the expense and potential drug toxicity of false + TSTs in BCG vaccinated populations, c) implementing universal 12 week, 12 dose LTBI therapy to improve LTBI treatment completion rates and decrease future TB burden. Of the 1310 individuals with LTBI in this clinical cohort we will utilize IGRA’s to improve specificity of identification of LTBI.
cases and with universal application of supervised 12 week, 12 dose LTBI therapy we will improve completion rates for LTBI therapy over baseline by 3% in DY 4 and 5% in DY 5. Of the 178 patients with active TB we will increase treatment completion rates over baseline by 3% in DY4 and 5% in DY5 with universal application of directly observed therapy and selective use of inpatient therapy. **Category 3 Outcomes:** Our goal in DY4 is a 3% improvement in LTBI treatment completion over baseline for LTBI and 3% improvement in therapy of active TB over baseline in urban and rural minority populations and in DY5 a 5% improvement in LTBI treatment completion over baseline and 5% improvement in therapy of active TB over baseline in urban and rural minority populations. The DY 4 and DY 5 targets for the proposed strategies were determined by considering recent trends in LTBI and TB disease epidemiology in Texas and the funding available for the state TB program, both of which have been relatively unchanged with a realistic assessment of the potential for any intervention to significantly improve in the context of these static trends.

**Project Description:**

Implement a strategy for comprehensive, cost-effective and integrated management of tuberculosis (TB) infection and disease in urban and rural minority communities through a partnership between the Texas Center for Infectious Disease (TCID), the Texas Department of State Health Services (DSHS) and the University of Texas Health Science Center, Tyler (UTHSCT).

**Goals and Relationship to Regional Goals:**

Collaboration between these 3 entities focuses a full scope of expert physician support of DSHS, with the goal of improved TB care for minority populations including targeted testing for latent TB infection (LTBI), effective treatment of LTBI for prevention of future TB cases, TB case identification with appropriate outpatient and/or inpatient TB therapy and aggressive contact investigation with treatment of LTBI associated with active TB cases. These goals will be accomplished according to CDC and DHHS evidence-based strategies with an emphasis on cost-effectiveness. These goals will be accomplished through the application of new and cost-effective diagnostic tests such as the interferon gamma release assays (IGRA) and the use of new cost-effective treatment strategies such as the 12 week, 12 dose treatment strategy for LTBI. The project will be guided by physicians with the most TB experience in the state. This comprehensive approach will not only improve outcomes long term, but will also decrease costs for TB management in both the short and long terms.

The project will take advantage of existing DSHS infrastructure and policy for basic public health functions, namely the use of directly observed therapy (DOT) for treatment of active TB disease, and contact investigation to identify LTBI cases associated with active TB disease cases. In addition all patients who otherwise would have been evaluated with a tuberculin skin test (TST) will be evaluated instead by an IGRA. The IGRA have been repeatedly shown to be more specific than TST when testing BCG vaccinated populations. Although the IGRA are somewhat more expensive than TSTs from the perspective of initial costs, they produce net savings long term by avoiding unnecessary therapy for patients with false positive TSTs due to previous BCG vaccination who represent the majority of patients diagnosed with TB in the U.S. The IGRA have no cross reactivity with BCG as do the TSTs. Additionally, for those patients who are found to have LTBI, the standard treatment will be a 12 dose, 12 week regimen with rifapentine and isoniazid (INH). Although the rifapentine is a relatively expensive medication, this regimen also produces long term net savings resulting from better patient adherence with the regimen compared to INH and, therefore, fewer cases of active TB in patients identified with LTBI. Treatment completion rates for INH regimens are routinely in the 60% range, whereas recent data utilizing the 12 week 12 dose regimen by DOT shows treatment completion in the 80% range. The logical anticipated outcome of improved LTBI adherence and treatment
completion would be decreased TB disease rates in the future. Overall, the combination of routine IGRA use and application of the 12 week LTBI treatment strategy offers the potential for significant cost savings without sacrificing benefit to individuals and the public health in general. Additionally, the expertise of the supervising UT physicians allows efficient and cost-effective diagnostic and therapeutic decisions throughout the course of TB disease or LTBI for all patients.

We propose that UT physicians coordinate all aspects of TB care in 2 DSHS Health Service Regions (Health Service Regions 8 and Region 4/5N) between DSHS personnel and UTHSCT physicians at two inpatient facilities, TCID (RHP 6) and UTHSCT (RHP 1). Close cooperation between UTHSCT, TCID, HNTC and DSHS promotes optimization of medically effective and cost-effective care and can serve as a model for management of TB throughout the state of Texas with partnerships between DSHS and other UT health components. The advantages of the system of cooperation between UTHSCT and DSHS include the following.

1) There is a central authority (i.e. UTHSCT) that DSHS personnel can access for questions regarding TB patients (either with active disease or LTBI). In emergency situations, UTHSCT physicians can be reached 24 hours per day, 7 days per week. A major problem throughout the state is the easy identification of a responsible physician for handling TB patients and difficult management questions. If this proposal is implemented, DSHS personnel will never be left without physician support or with the prompt identification of a physician responsible for a specific problem. When appropriate, the UTHSCT personnel also facilitate inpatient TB therapy.
2) There are identified and coordinated inpatient facilities (UTHSCT and TCID) for those few TB patients requiring referral or transfer on either an elective or emergency basis.
3) There are designated UTHSCT physicians, expert in the care of TB, available to support DSHS personnel in the management of any TB patient at all levels including telephone consultation, outpatient management and inpatient care if necessary. All patients with TB disease and LTBI are managed by a centrally located, expert staff according to national and DSHS guidelines. The physicians provide evidence based care consistent with national and state guidelines.
4) Statewide adoption of this model (DSHS management of TB and LTBI supported by UT faculty) would offer the same benefits described above to minority populations and DSHS personnel throughout the state. DSHS personnel would have rapid access to reliable and expert physician support and easily obtained admission of patients to respiratory isolation if necessary. There would be no ambiguity about the responsibility for management of the patient. The DSHS personnel could go directly to their designated UT facility for support including consultation and hospitalization. Access to the entire UT system would add a dimension missing in the current proposal that is limited to 2 DSHS regions, that is, access to multiple medical specialties (especially surgical subspecialties), and, therefore, the ability to provide total care to the patient with TB. The majority of hospitalized TB patients would still be treated at TCID after stabilization at local UT facilities.

Project Goals:
- Provide predictable and reliable expert physician support for DSHS personnel at all levels of TB care.
- Increase overall access to TB care in minority populations.
- Increase targeted testing for LTBI in high risk minority communities.
- Provide routine testing for LTBI with interferon gamma release assays instead of tuberculin skin testing to minimize false positive tests in BCG vaccinated patients and avoid unnecessary LTBI therapy.
- Provide routine treatment of LTBI through a 12 dose, 12 week regimen administered by DOT to improve patient adherence and completion of LTBI therapy.
• Provide expert consultation and direct patient oversight of all active TB cases.
• Facilitate continuity of TB care through all phases including LTBI therapy, outpatient TB therapy and, when necessary, inpatient therapy.
• Facilitate hospitalization for TB care of those few patients who cannot be successfully treated as outpatients.
• Provide a model for statewide TB management through complete integration of TB resources between DSHS (TCID) and UTHSCT, including HNTC.

This project meets the following regional goals:
• Further develop a coordinated care delivery system

**Challenges:** The high percentages of minority patients with TB compared to white, has remained stubbornly, frustratingly and consistently high. There are likely multiple explanations for this observation including distrust of the medical establishment, fear of legal reprisal for non-citizens and lack of culturally appropriate education and outreach materials. To some degree these challenges can be overcome with increased resources focused on the minority communities, and identification of the TB control effort with one trusted and non-threatening entity, the University of Texas. There are obstacles to the statewide application of this model that would need to be addressed. First, there are Texas Health Service Regions (HSRs) without a UT affiliated facility. Appropriate alternative treatment agreements would have to be made in those areas. Again, transfer of long-term care patients to TCID would be anticipated. Second, some HSRs have multiple (or complex) layers of Health Department authority that might thwart easy assignment of authority to UT. Third, some HSRs have long-term and ongoing associations with academic institutions other than UT (even in Regions with a major UT health care facility). Not all HSRs lack adequate physician support. These physicians would need to be covered under the broad umbrella of UT physician management oversight.

**5-Year Expected Outcome for Provider and Patients in HSRs 8 and 4/5N:**
1) Full integration of TB care at all levels (LTBI testing, LTBI treatment, TB case identification, TB case management) in HSR Regions 8 and 4/5N coordinated between DSHS and UT physicians (UTHSCT, TCID, HNTC)
2) Increased numbers of minority persons (Black and Hispanic) screened for LTBI
3) > 90% completion of therapy for active TB
4) > 95% therapy of active TB by DOT
5) >10% increase in identification of LTBI patients
6) >10% improvement in LTBI treatment completion
7) > 10% reduction in overall active TB disease rates

**Starting Point/Baseline:**
1385 cases of TB disease were reported in Texas in 2010, a rate of six per 100,000 population. The number of cases fell only to approximately 1300 cases in 2011. TB can strike anyone, but is more likely to be found in those born in a foreign country, people with diabetes, people with HIV/AIDS, the homeless, and those that work in health care. Alcohol abuse is associated with more than 21 percent of TB cases and 11 percent of cases are associated with detention facilities. For U.S. born citizens, there is an alarming disparity in TB incidence rates between whites and minority communities. In Texas, 51.3 percent of reported TB cases in 2010 were among Hispanics, 18.4 percent were among African Americans, 14.8 percent were among Whites, 14.8 percent were among Asians. As can be seen in the accompanying table, the TB case percentage among African Americans was considerably higher than the state average in Department of State Health Services (DSHS) Health Service Region (HSR) 4 while the TB case percentage for Hispanics was considerably higher than the state average for HSR 8. These two ethnic minorities are clearly disproportionately affected by TB compared with white Texans based
on their respective representation in the general Texas population. This disparity is magnified given the more robust declines in TB incidence in the white populations in the last decade compared with the minority communities.

An estimated 4.2% of the U.S. population or ~11 million persons have latent *M. tuberculosis* infection (LTBI) according to a 1999-2000 tuberculin skin test (TST) survey. Reactivation of LTBI accounts for ~70% of incident TB disease in the U.S. For each 1% lifetime risk of reactivation TB disease in this group, 110,000 TB cases might be expected from this reservoir of LTBI over the next 40 years (1/2 the population's life expectancy). Eliminating TB in the U.S. and Texas will require preventing these cases. Appropriate targeted testing of high risk populations including aggressive contact investigation around active TB cases is a vital part of the TB elimination strategy. The use of interferon gamma release assays (IGRAs) instead of tuberculin skin tests (TSTs) will eliminate the need to treat BCG vaccinated patients with false positive TSTs. In principle, treating LTBI with 6-12 months of isoniazid (INH) can substantially reduce TB incidence, however, patient adherence with INH self-administered regimens is poor so that avoidance of TB disease is suboptimal with this strategy. With the new 12 dose 12 week INH/rifapentine regimen, patient completion rates are significantly better than with INH alone due both to the need to administer the 12 week regimen by directly observed therapy (DOT) and because of better patient tolerance of the therapy. It is clear that aggressive identification of LTBI cases followed by effective LTBI therapy is an effective strategy for preventing new cases of active TB disease. Aggressive targeted LTBI testing strategies in high risk populations such as minorities (Black and Hispanic populations) are clearly effective in reducing TB case rates. Three entities have the most influence and impact on TB care in the state including UTHSCT, TCID and the Heartland National TB Center. Aside from unwavering dedication to TB control in Texas, the unifying factor for each of these organizations is that they are all staffed by UTHSCT faculty.

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<th>White</th>
<th>Black</th>
<th>Hispanic</th>
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<th>Total</th>
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<td>18.4%</td>
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UTHSCT has been involved with TB care in Texas for more than a half century. UTHSCT maintains the capability to safely evaluate and if necessary hospitalize contagious TB patients in respiratory isolation. Currently, faculty at UTHSCT include 5 board certified pulmonary physicians (4 adult and 1 pediatric), and 2 board certified infectious disease specialists, each with decades of experience treating TB. UTHSCT is now also the home of a large Public Health Laboratory that performs interferon gamma release assays for diagnosis of LTBI.

The Texas Center for Infectious Disease (TCID) has provided inpatient TB care for nearly 60 years and is currently the only free standing inpatient facility dedicated to TB care in the U.S. TCID hospitalizes persons with the most complicated TB cases. TCID treats the majority of the 4-6% of TB patients in Texas who need hospitalization. Reasons for admission to TCID include non-adherence with outpatient therapy, court ordered (quarantined) TB treatment where a patient’s non-adherence...
with TB medication regimens has proven to be a threat to public health or safety, TB drug toxicity, management of co-morbidities such as HIV infection or diabetes and management of drug resistant TB cases. TCID is unquestionably the premier facility in the U.S. for inpatient management of patients with drug resistant TB. TCID is Texas’ designated hospital for TB. The 3 Infectious Diseases (ID) board certified physicians providing the inpatient TB care at TCID are UTHSCT faculty.

The Heartland National TB Center (HNTC) is a partnership between DSHS and UTHSCT and one of four national TB centers funded by the Centers for Disease Control and Prevention (CDC). HNTC was originally funded in 2005 to provide TB training, technical assistance, product development, and medical consultation to a 13-state region and two big cities from the border with Mexico to the border with Canada. The HNTC is housed at TCID in San Antonio, Texas. HNTC also supports CDC efforts to address health equity by researching and using information/data on health disparities and social determinates to identify communities disproportionately affected by TB. Therefore, training and product development, implementation, and evaluation include social determinates of health and ensure culturally appropriate interventions for target audiences. All employees at HNTC including the physician medical director and assistant medical director are UTHSCT faculty.

UTHSCT faculty has the most experience, the greatest expertise and the most influential positions related to TB care in the state. This project would bring about a direct line of shared responsibility between UTHSCT physicians and DSHS personnel on the front line of Texas TB care in two DSHS HSR regions. This project will hopefully serve as a model for TB care in the entire state.

Rationale:

This project will comprehensively improve TB control in urban (DSHS HSR 8) and rural (DSHS HSR 4/5N) minority communities in Texas. The current process for TB control is under the aegis of DSHS, but also involves multiple frequently over-lapping jurisdictional boundaries with roles and responsibilities not always clearly defined. Personnel from various components of the Texas public health system (city, county, state) can be faced with demanding responsibilities without the accompanying specific authority or support to adequately address those responsibilities. This proposal offers a clear and comprehensive mechanism for cost-effective management of all aspects of TB care in minority populations in the state, the most important demographic for TB in Texas, through a partnership between the three most experienced providers of TB care in the state, DSHS, TCID, UTHSCT. This project will fully integrate the core public health functions of DSHS, such as TB therapy by DOT and contact investigation, with the formidable and unparalleled TB expertise available under the aegis of UTHSCT.

Improving TB outcomes through existing agencies and relationships presents several challenges. The DSHS TB control funding has been essentially flat, in real dollars, for several years. In the context of attrition of experienced personnel through retirement etc. and flat funding, it is unlikely that DSHS can maintain its current level of TB expertise and experience much less significantly expand its effort with current resource levels. The TB case rate in Texas has been steadily declining for more than a decade, but in the last 2 years there has been only an anemic decline in TB incidence that may presage a plateau in the previously encouraging progress, or worse, a reversal of that progress. The number and availability of TB experts in the state is declining due to attrition (retirement, etc.), so that identification of these experts will only become more difficult. The percentages of minority patients (black and Hispanic) with TB and LTBI are also disturbingly high and consistently flat compared with white patients suggesting at least a relative lack of progress in these populations. Blacks and Hispanics have an approximately 8X higher TB rate than whites, clearly disproportionately high based on their respective percentages of the population. It would be difficult for DSHS with its present state of funding and staffing to dedicate the resources to narrow this gap. We will provide in DY3 the
necessary education and training for DSHS personnel to successfully implement the new and innovative LTBI diagnosis and treatment strategies through face to face trainings and web based education opportunities. We will also reinforce evidence-based and CDC/DSHS approved treatment strategies for TB disease.

**Unique community need identification numbers the project addresses:**
- RHP 6 CN.2- Chronic disease and related health disparities
- RHP 1 CN.1- Insufficient access to primary and specialty health care services

This project will implement a strategy for comprehensive management of TB infection/disease in DSHS HSR 8 and 4/5N.

**Related Category 3 Outcome Measure(s):**

OD-11 Addressing Health Disparities in Minority Populations:
IT-11.1 Improvement in Clinical Indicator in identified disparity group

**Reasons/rationale for selecting the two Outcome Improvement Targets:**

Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve comprehensive, evidence based TB care of TB for urban and rural minority communities in Texas. This initiative will undertake a series of steps which incorporate core project components to achieve this collaboration between DSHS, UTHSCT, TCID and HNTC. Category 3 process outcomes include project planning (P-1) in DY2, establishing baseline rates (P-2) in DY3, and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, the standalone measure selected is IT-11.1 Improvement in Clinical Indicator in identified disparity group. Two clinical indicators to be improved and disparity groups have been determined by the provider. The disparity group is minority (Black and Hispanic) urban and rural populations at risk for TB in DSHS HSR #8 and #4/5N. The clinical indicators to be improved include percentage of TB patients receiving therapy of active TB by DOT and improved LTBI treatment completion rates.

As a non-acute care hospital without an emergency department or intensive care unit TCID has no statistically significant data to report on any of the Outcome Domains 1-3 or 5 in Category 4.

**Relationship to other Projects:**

The project team will work with the anchors in both RHP regions (6 and 1) to share information about new treatment regimes for persons with active and LTBI as well as referral for specialty consultation and care with other performing providers.

**Relationship to Other Performing Providers’ Projects in the RHP:**

This project is a collaborative with an academic medical center performing provider in RHP1; it will serve as a referral destination for other projects in RHP 6 that provide primary and behavioral health care services.

**Plan for Learning Collaborative:**

The leadership team for this project will actively participate in the face-to-face meetings and other opportunities to share challenges and lessons learned with other health care providers in both RHP 6 and 1.

**Project Valuation:**

This represents an innovative and ambitious project to enhance and expand the control of TB in minority communities in 2 HSRs in Texas that encompass both urban and rural minority populations. This proposal incorporates the existing public health infrastructure of DSHS and the extensive TB expertise of UT physicians at UTHSCT, TCID and HNTC in a collaboration that promotes expert, cost-effective, evidence-based TB control with seamless continuity of care at every level. The expertise of
UT physicians with evidence-based CDC and DSHS treatment guidelines insures avoidance of unnecessary and costly diagnostic and treatment strategies while the application of new diagnostic (IGRA testing) and treatment strategies (12 week LTBI therapy) further reduce costs by focusing resources on interventions of proven public health value at a lower financial cost. Improved completion rates for LTBI therapy will also decrease the number of LTBI patients progressing to active TB and avoid the considerably higher costs associated with treating active TB. The value of this project is justifiable on the basis of:

1) Enhanced access to a comprehensive fully integrated TB care process that utilizes the existing DSHS public health infrastructure and physician expertise from UT.
2) Implementation of universal LTBI testing with IGRA thereby limiting the expense and potential drug toxicity of false + TSTs in BCG vaccinated populations.
3) Implementing universal 12 week, 12 dose LTBI therapy to improve LTBI treatment completion rates and decrease future TB burden.
4) Insure universal application of evidence based treatment guidelines from CDC and DSHS for LTBI and TB disease.
5) The ultimate value of this project is decreased TB morbidity in Texas with an attendant significant decrease in healthcare and public health costs.

References:
12: Centers for Disease Control and Prevention (CDC). Decrease in reported tuberculosis cases - United States, 2009.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133257904.3.1</th>
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<td>P-1: Development of innovative evidence-based project for targeted population.</td>
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<td><strong>Metric 1</strong></td>
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<tr>
<td>P-1.1: Document innovational strategy and plan</td>
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<td>Baseline/Goal: Develop innovational plan</td>
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### Learning & Diffusion of Strategic Plan

Data source: a) Documentation of implementation – record of conferences and training sessions  
b) Diffusion of innovative treatment information to health providers

**Milestone 3 Estimated Incentive Payment:** $1,538,537

### Metric 2 I-7.2: Increase number of encountered as defined by the intervention

**Goal:** Increase number of total visits for reporting period  
**Data Source:** EHR

**Milestone 4 Estimated Incentive Payment:** $2,692,440

**Milestone 5 Estimated Incentive Payment:** $2,140,500

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<th>Year 4 Estimated Milestone</th>
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**Total Estimated Incentive Payments for 4-Year Period:** $10,809,948
Identifying Project and Provider Information:
Title: 2.12.1 Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions
Unique RHP ID#: 136141205.2.1 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): This project will implement a care transitions program specifically to improve access and will involve follow up calls to and/or home visits to better activate patient engagement by a transition coach following a routine visit and or discharge from an acute setting. This will be part of a broader model of care coordination tailored to improve and meet patient preferences and thus avoiding an emergency department visit. Currently, automated telephone calls post discharge are conducted through Illuminate, which will route the user to be contacted by a transition coach within 48 to 72 hours, if the user indicates dissatisfaction or a concern.

Need for the project: Currently there is no consistent process for identifying and addressing patients at risk for readmission. There is increasing evidence to support the need for immediate follow-up for patients post discharge from acute care, to address the needed education not heard or understood during the discharge process and to assure that services coordinated in the discharge process have been delivered. A sampling of data specific to all Medicare and Medicaid discharges between December 2010 and November 2011 reflects larger percentages of readmissions within the first 14 days post discharge, often times before the scheduled follow-up provider appointments.

Target population: The target population will include the Medicaid funded and uninsured patients who comprise 62% of patients who receive services at University Health System including those patients identified as high risk for readmission discharged from University Hospital

Category 1 or 2 expected patient benefits: In DY2, best practices (such as Partnership for Patients discharge checklists and protocols) will be implemented for effectively communicating with patients and families during and post discharge. Dedicated coaches to this program will be utilized to improve adherence to discharge and follow-up care instructions. In DY3 through DY5, care transitions processes will be reevaluated for improvement, hardwired and expanded resulting in improved care coordination and transition of patients.
Category 3 outcomes: 136141205.3.11 IT-2.13 Other Admission Rate (Stand-alone measure)

- **DY4** – Reduced rates of readmission by TBD% for patients identified and managed by the Transitions of Care Project.

- **DY5** - Reduced rates of readmission by TBD% for patients identified and managed by the Transitions of Care Project.

**Project Description:**

The goal of the project is to implement a care transitions program specifically to address the window of time between discharge and either a return EC visit and/or PCP clinic visit. It is during this window of time that patients struggle with discharge instructions, understanding and access to medications, and access to ambulatory clinic/provider visits. This project was selected for needed approaches to improving the patient experience and health outcomes by early/proactive identification of high risk populations for readmission before discharge, improving the discharge process, improving communication and handoffs with Ambulatory and post acute providers during the transition period, and assuring patient engagement especially within the first 48 hours of discharge, and, as necessary, making home visits.

The initiative/project will utilize all core project components (a-g) as follows:

a. Review and implement best practice models for the population served that addresses readmission rates, reasons and time frames for readmission and post discharge support/calls.

b. Utilize the IHI STAAR chart review tool to identify key drivers for readmissions.

c. Develop and utilize Allscripts™ (Care Coordination software), to facilitate continuity of care for patients across all settings.

d. Establish dedicated roles to design implement and hardwire processes including post discharge support to improve the window of time between discharge and access to providers.

e. Incrementally implement post discharge planning support based on select interventions from Project RED, the Coleman Model, and Boost based upon lessons learned.

f. Assemble and work with prioritized post acute providers to improve processes for patients in transition

g. Regularly identify lessons learned and, utilizing Lean processes, work to eliminate waste and improve transitions of care processes.

Five year expected outcomes include improved clinical outcomes for patients, and decreased EC visits, admissions, and readmissions. The organization will benefit through future cost avoidance and financial penalties.

Current challenges facing University Health System includes the lack of:

- A coordinated infrastructure to support the initiative
- Definition of roles and responsibilities with accountabilities specifically ingrained to support transitions of care
- Policies and procedures, and thus, variation in processes
- Limited patient engagement with unique socioeconomically challenged population
Starting Point/Baseline:

A Transitions of Care Committee was established in 2010 with the following results:

- Dedicated appointments can now be established within provider templates within the EMR as “post hospital discharge appointments.”
- Implementation of an automated message through the ADT system to advise providers via a secure health message of his/her hospitalized patients and discharges.
- Establishment of post discharge calls 24 and 72 hours post discharge. Post discharge calls at 24 and 72 hours have recently switched to the Illuminate automated telephone system.

Variation and inconsistency continue in these process flows. Currently, 35% of patients discharged from University Hospital receive a call to assess the patients understanding of the medical regimen, follow up appointments, and medication reconciliation; this number is based on one specific service line that aggressively inputs the consult needed for activation of the post discharge call. Presently, the follow-up discharge appointment has a 20% no-show rate, and there is no current understanding of the reasons for failure to keep appointments.

In 2012, acute care coordination staff became predominantly unit-based in order to better align with Nursing regarding plan of care and discharge processes. There were two Lean events dedicated to the discharge process. The first event was dedicated to the discharge process on one pilot unit with no evidence of house-wide impact to date. The second, a Value Stream Analysis, occurred in October to prioritize transitions of care needs and assign the type of Lean effort per project, accordingly:

- Standardization of the post discharge process for internal providers
- Improve Access to CareLink for acute population
- Standardize process between Ambulatory Connections and Access Plus
- Standardize post discharge paperwork, appointment information, letter, medical home.
- Develop a Care Coordination Clinical Summary in the EMR
- Develop and implement a post discharge call methodology with designated staff and support processes

Rationale:

The Transitions of Care project enables University Health System to continue to prioritize needed attention to processes from discharge until follow-up appointment in order to better engage the patient, coordinate care and improve clinical outcomes.

This project addresses a high prevalence of chronic disease and related health disparities that require greater prevention efforts and improved management of patients with chronic conditions, which is in line with community need, CN.2. The project also addresses the lack of access to medical care due to high rates of un-insurance, reflective of community need, CN.3.

The project will “significantly enhance” pre-existing efforts as stated per the baseline above. Although the work was thorough and fruitful, the following gaps remain, which will be rectified with the proposed program:
- how to better identify patients at high risk before discharge and at home
- education at discharge and via post discharge calls
- referral processes
- improved internal and external handoffs and communication, and
- patient engagement.

**Related Category 3 Outcome Measure(s):**

There is increasing evidence and logic to support the need for immediate follow-up for patients post discharge from acute care, not only for patient satisfaction, but more importantly to address the needed education not heard or understood during the discharge process and to assure that services coordinated in the discharge process have been delivered. A sampling of data specific to all Medicare and Medicaid discharges between December 2010 and November 2011 reflects larger percentages of readmissions within the first 14 days post discharge, often times before the scheduled follow-up provider appointments.

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Medicare FFS</th>
<th>Overall</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Discharges</td>
<td>% Mcaid</td>
<td>Discharges</td>
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<tr>
<td>Readmits same day</td>
<td>8</td>
<td>3.9%</td>
<td>65</td>
</tr>
<tr>
<td>Readmits 1-7 days</td>
<td>77</td>
<td>37.9%</td>
<td>95</td>
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<tr>
<td>Readmits 8-14 days</td>
<td>50</td>
<td>24.6%</td>
<td>80</td>
</tr>
<tr>
<td>Readmits 15-30 days</td>
<td>68</td>
<td>33.5%</td>
<td>124</td>
</tr>
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</table>

The purpose of selecting the outcome measure in category three will be to measure the impact of the transitions of care project on a decrease in admissions, EC utilization, and readmissions for patients impacted by the project.

**OD-2 Potentially Preventable Admissions**

- **IT-2.13 Other Admission Rate (Stand-alone measure)**
  a. Numerator: Readmitted patients managed by TOC project
  b. Denominator: All readmitted patients to University Health System within 30 days
  c. Data Source: EMR/IDX/Crimson/Truven Health/Allscripts

**Relationship to other Projects:**

The project is related to other projects within the DSRIP:
- 92414401.2.2 – Enhance/expand the medical home
Care Transitions will support the medical home by working to assure patient access and engagement
136141205.2.2– Redesign to improve patient experience
Improvements in patient experience and engagement will be a byproduct of transitions of care. The belief is that once the processes are put in place and the system is improved, patient satisfaction will improve.
136141205.2.3 – Apply process improvement methodology to improve quality/efficiency
Two Lean events specific to discharge and care transitions have or will soon occur.
136141205.2.4 – Establish/expand a patient care navigation program
The Care Navigation Program and overarching Care Coordination Plan will be impacted as needs continue to be assessed and prioritized.

**Relationship to Other Performing Providers’ Projects in the RHP:**
In addition to University Health System, CHRISTUS Santa Rosa and Guadalupe Regional Medical Center are also addressing the need for transitions of care programs. As projects evolve, there may be the opportunity for sharing best practices, ideas, and solutions across the RHP.

**Plan for Learning Collaborative:**
In addition to University Health System, CHRISTUS Santa Rosa and Guadalupe Regional Medical Center are also addressing the need for transitions of care programs. As projects evolve, there may be the opportunity for sharing best practices, ideas, and solutions across the RHP.

**Project Valuation:**
Project valuation for an efficient and comprehensive Patient Care Transition Program is prioritized as a Pass 1. As there are approximately 22,000 or more discharges a year, around 55,000 EC visits, and > 580,000 Ambulatory visits expected in 2013, better transitions of care impact is defined through cost avoidance, a reduction of admissions and readmissions as well as a decreased EC utilization.
<table>
<thead>
<tr>
<th>136141205.2.1 PASS 1</th>
<th>2.12.1</th>
<th>2.12.1 A - G</th>
<th>2.12.1 DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital</td>
<td>TPI - 136141205</td>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Other Admission Rate (Stand-Alone Measure): Admission rate of patients managed by TOC project</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions. Metric 1 [P-1.1]: Care transitions protocol Baseline: 0 Goal: Establish Care Transition protocols Data Source: UHS Corporate Policies</td>
<td><strong>Milestone 3</strong> [P-2]: Implement standardized care transitions processes Metric 1 [P-2.1]: Care transitions policies and procedures Baseline: Year 2 P&amp;P’s created Goal: Continue to identify, and edit all P&amp;P’s for program Data Source: Submission of protocols, and other care transitions materials; Corporate, Departmental, and Ambulatory P&amp;P’s</td>
<td><strong>Milestone 5</strong> [P-X pg. 7]: Assess efficacy of processes in place and recommend process improvement to implement, if any. Metric 1 [P-X pg. 7]: Perform at least two PDSA workshops to determine the success of the program, document whether the anticipated metric improvements were met, and modify the program if necessary. Baseline: 0 Goal: Conduct and document 1 quarterly PDSA workshop. Address Transitions of Care Program and review population for EC utilization, admissions, and readmissions. Data Source: Meeting minutes and Sign-In sheets</td>
<td><strong>Milestone 7</strong> [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes Goal: Sixty-five percent (1,375) of population on case management related registry will be monitored through care transitions. Data Source: Sunrise, Allscripts/IDX Milestone 7 Estimated Incentive Payment:$3,409,748</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,886,264</td>
<td>Milestone 3 Estimated Incentive Payment: $2,057,813</td>
<td>Milestone 5 Estimated Incentive Payment: $2,057,813</td>
<td>Milestone 7 Estimated Incentive Payment:$3,409,748</td>
</tr>
</tbody>
</table>

**Milestone 2** [P-7]: Develop a staffing and implementation plan to

**Milestone 4** [P-5]: Using a validated risk assessment tool, create a patient

**Milestone 6** [P-7]: Develop a staffing and implementation plan to

**Milestone 7** [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes Goal: Sixty-five percent (1,375) of population on case management related registry will be monitored through care transitions. Data Source: Sunrise, Allscripts/IDX

Milestone 7 Estimated Incentive Payment:$3,409,748
accomplish the goals/objectives of the care transitions program.  

**Metric 1 [P-7.1]:**  
Documentation of the staffing plan  
Baseline: 0  
Goal: Align resources and increase staffing of the appropriate skill mix as needed. Technology to support patient access and encounters may be needed.  
Data Source: 

<table>
<thead>
<tr>
<th>Milestone 2 Estimated Incentive Payment: $1,886,264</th>
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</table>
| Identification system. Metric 1 [P-5.1]: Patient stratification system  
Baseline: 0  
Goal: Train, Implement, and utilize a patient stratification tool to assess patients for potential risk of readmission within 30-60 days post discharge.  
Data Source: Evidence as demonstrated by other public health systems  
Milestone 4 Estimated Incentive Payment: $2,057,813  
Milestone 5 Estimated Incentive Payment: $2,063,795  
Milestone 6 Estimated Incentive Payment: $2,063,795 |

**Milestone 6**  
[I-14]: Implement standard care transition processes in specified patient populations.  
**Metric 1 [I-14.1]:** Measure adherence to processes  
Goal: 50 percent (1,050) of population on case management related registry will monitored through care transitions.  
Data Source: Sunrise, Allscripts/IDX  

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $3,772,528</th>
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<tbody>
<tr>
<td>Year 3 Estimated Milestone Bundle Amount: $4,115,626</td>
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<tr>
<td>Year 4 Estimated Milestone Bundle Amount: $4,127,590</td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $3,409,748</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,425,492**
Identifying Project and Provider Information:
Title: 2.4.1 Improve processes to measure and improve patient experience: University Hospital-The New “U”
Unique RHP ID#:136141205.2.2 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): This project will develop and implement a comprehensive patient-centered training program based on Planetree/NRC Picker protocol. This protocol was developed based on responses by 90 anonymous focus groups (representing 35 hospitals and 645 patients). The program will build a culture centered on providing a positive experience for all patients cared for within the Health System.

Need for the project: Enhancing awareness and understanding, among University Health System staff regarding patient-centered care, are critical to delivering high quality care that is efficient, timely and safe. A review of University Health System’ patient experience scores demonstrate a need to develop and implement a comprehensive orientation on key aspects of patient-centered care.

Hospitals around the country have seen success from this type of approach:
- Arkansas Children’s Hospital now ranks in the 90th percentile in patient and employee satisfaction
- Florida Hospital for Children, a 1,200 bed facility, went from the bottom 10% in patient satisfaction into the high 90th percentile nationwide

Target population: The target population will include all University Health System patients who are economically underserved or uninsured. Medicaid-funded (19%) and uninsured (43%) persons represent 62% of the patient population served by the Health System. The target population and their families will benefit from this project by being empowered to participate in their care.

Category 1 or 2 expected patient benefits: Adopting a patient-centered approach to care at University Hospital will allow the patient and family to feel empowered and to more fully participate in treatment plans. University Health System will be providing high quality care at every encounter and will be meeting national patient safety guidelines. Patient-Centered Care strengthens relationships and collaboration between patients, their families and their caregivers. It actively promotes family involvement and sets the foundation for quality care delivered in a
safe environment.

Category 3 outcomes: - IT-6.1 – The goal is to increase patient satisfaction scores.

- DY4 – Increase patient satisfaction by 2%.
- DY5 – Increase patient satisfaction by 2%.

**Project Description:**

The goals of the program are to develop and implement a comprehensive patient experience training program for University Hospital. The Executive Director of Patient-Centered Care will write and disseminate a strategic plan on how the health system will be hard-wired towards a patient-centered approach. A steering committee will be created and comprised of health system leaders, staff, patients and their families. Monthly meetings will focus on directing this initiative using the *Patient-Centered Care Improvement Guide* (Planetree, Inc and Picker Institute). Patient-centered care will be coordinated and monitored on an on-going basis. Re-design to improve patient experience includes appointing an executive director to lead the health system through a culture change, by working in coordination with the Center for Learning Excellence department to develop and implement training programs focused on patient-centeredness.

Getting buy-in from all stakeholders and educating the new concept of patient-centered care is our primary challenge. Getting the right people on board will be crucial, as will having the right patients and family members on the steering committee team. Improving the patient experience is in actuality a re-orientation of the health care delivery system as it is practiced throughout our health system. The challenge comes not only with teaching and modeling the patient centered philosophy but in hardwiring all current staff and future employees. Each staff member must be willing to re-think and comprehend that being patient centric and delivering customer service excellence at the highest level is essential for both quality care and safety. The cost to educate staff (over 5,000 employees) and provide trainers will also be a challenge. This project will address these challenges by continuous process improvement of competencies, employee mentoring and training for new employees (Disney’s Model – Building a Culture of Healthcare Excellence).

The expected 5 year outcome will be a comprehensive customer service training program that is effective in shifting our culture and responsive to the training needs of current and new employees (5000 employees). With this accomplishment we expect improvements in patient satisfaction results by 2% annually from baseline.

Patient Centered Care aligns well with the Triple Aim Plus which is reflected in regional goals. The proposed program meets criteria for improving patient experience and improving quality outcomes.

**Starting Point/Baseline:**

Currently there is no program in place for training or educating staff on improving the patient experience. Roles and responsibilities are being developed and are expected to be established during DY2 along with a comprehensive strategic plan to shift our culture to a patient - centered model.
Rationale:
The reason for adding an executive director with a focus on patient-centered care and implementing on-going training may seem like an obvious approach. However, healthcare is a complex system that is often-times difficult for the community at large to access or even understand. This project represents a new initiative for our health system and a change from the culture of “we’ve always done it that way” to partnering with our patients and their families. With the development and introduction of HCAHPS and CGCAHPS there is now a tool to evaluate the way care is delivered using a philosophy that it is provided from the patient’s perspective. UT House Staff and Medical Students are all oriented on HIPAA regulations, Patient Centered, Cultural Diversity and Infection Control. UT Medicine – has recently engaged a consulting firm “Turning Point” to assist them in improving their customer service. UT Medicine physicians are also engaged in nursing shared governance as well as recently attending Patient Centered conference and HCAHPS boot camp.

Components:
- Organizational Integration and Prioritization of patient experience
- Data and Performance Measurement using HCAHPS
- Implement processes to improve patient experience accessing clinical practice
- Develop process to certify independent survey vendors

Implementation of the components will be done by writing and disseminating a patient/family experience strategic plan (P.2, DY2), developing a training program on patient experience (P-15,DY2), integrating the patient experience into employee training (P-4, DY3), developing a new patient experience tool or revising and improving the current one (P-8, DY3), develop a plan to roll out a the collection of patient experience information from an area in the organization that does not currently collect such data (P-9, DY4), and improving patient satisfaction improvement scores (I-16.3, DY5).

The project will guide us through those topics that are important to the healthcare consumers using our facilities. Using the HCAHPS and CGCAHPS tools to both guide and measure will be key to the program’s success. In healthcare where evidence-based practice is so important, we will be systematic and rigorous in the study and implementation of patient-centered care. Creating a positive patient experience will be a priority and will be implemented using the Patient Centered Care Improvement Guidebook as a road map to successfully improving patient experience. Progress will be measured and monitored using the NRC Picker (HCAHPS and CGCAHPS) surveys.

This project addresses CN.1 Improve quality of healthcare delivery and patient experience.

The University Health System provider group (Community Medicine Associates) as employed providers take part in all orientation and Customer Service training or initiatives. A new initiative will be to work with Federally Qualified Health Centers where University Health System providers and patients are assigned to roll-out the use of NRC Picker surveys to gather data on the patients experience served in the FQHC areas. University Hospital has begun and will continue to use a curriculum of Customer Service training focused on the Disney model of Customer Service – Building A Culture of Healthcare Excellence. This new initiative will be a
great start to get all University Health System employees on the same page by teaching the basics of Customer Service (required of all employees). The Executive Director of Patient Centered Care in collaboration with other departments (Learning Resources, Human Resources, Patient Care Services and Patient Satisfaction) will monitor and be accountable for the sustainability of this program. Historically, customer service programs have not sustained as there has been no one individual or department assigned to monitor. This will be the primary focus of the Executive Director of Patient - Centered Care. Key to this effort will be that employees have an understanding of the philosophy of Patient-Centered Care and that applicants with outstanding customer service skills are hired to fill vacancies. We will know that we are improving, when we become the health system of choice and our customer service scores continue to improve.

Related Category 3 Outcome Measure(s):

IT-6.1 Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAPHS survey may be used to establish if patients: are getting timely care, appointments, and information; how well their doctors communicate; patient’s rating of doctor access to specialist; patient’s involvement in shared decision making, and patient’s overall health status/functional status.

RHP Priority
This outcome addresses the triple aim plus as presented in the RHP, by improving patient experience and improving quality outcomes.

Evidenced Based Rationale
This category 2 project of improving the patient experience initiative is using evidenced based best practices learned from Disney’s Model-Building A Culture of healthcare Excellence and Patient Centered Care philosophy. The foundation developed in this project will help position the organization to drive the outcomes of improvement in NRC Picker outcomes in our category 3 project.

Relationship to other Projects:
This project inter-relates with all of the DSRIP projects as a part of our Triple Aim Plus model for patient-centered care and specifically RD-4. – Patient Satisfaction.

136141205.1.3 Implement a Chronic Disease Management Registry
This project will help monitor current and future patient population in University Health System medical homes to improve healthcare outcomes.
136141205.1.4 Introduce, Expand, or Enhance Telemedicine/Telehealth
Telemedicine can be utilized to expand services and access to new clinical sites.
136141205.1.5 Expand specialty care; Behavioral health services
Mental health conditions are prevalent among the population University Health System serves. Expanding Behavioral health services will give the providers access to refer patients in need of these services at new primary care sites.
92414401.2.2 Enhance/Expand Medical Homes
Increasing access to primary care will give patient access to other specialty and preventive services offered in the medical homes.
136141205.2.2 Redesign to Improve Patient Experience
Providing the ability to access healthcare in a timely manner and in locations where services are needed will to a better patient experience.

136141205.2.3 Apply process improvement methodology to improve quality and efficiencies: LEAN methodologies will assist all projects in developing tools and training for the staff as it relates to process improvements in the quality and efficiencies in the care provided to the community.

136141205.2.4 Establish/Expand a Patient Care Navigation Program
This project will link much needed care coordination, social support and culturally competent care to vulnerable patient populations at risk for admissions and re-admissions.

136141205.2.5 Use of Palliative Care Programs
Patients in the medical homes with chronic end of life conditions will have an avenue that addresses patient populations who are at risk for suffering, frequent emergency room visits, admissions and death.

**Relationship to Other Performing Providers’ Projects in the RHP:**

92414401.1.1 Expand training of the primary care workforce
Training future providers in primary will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

**Plan for Learning Collaborative:**

This project lends itself to participation in learning collaborative as other Performing Providers in RHP6 seek to develop and expand customer satisfaction programs and measures in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve patient care experience.

**Project Valuation:**

The project achieves the waiver goal and meets community needs by measuring patient experience throughout the system as University Health System expands primary care in a predominantly Hispanic, underserved area of Bexar County. This program strengthens University Health System’s knowledge of patients’ perception of our new healthcare linkages with local community partners, defines barriers to care and assures improved quality care services to a target population that struggles with poverty, receive acute or emergency healthcare services only, and do not have usual providers. Patient satisfaction measures will be the predominant metric to understand how effective health system changes are being implemented and serve as the most useful tool to guide program improvement decision making.
<table>
<thead>
<tr>
<th>136141205.2.2 PASS 1</th>
<th>2.4.1</th>
<th>2.4.1 (A-D)</th>
<th><strong>2.4.1 IMPLEMENT PROCESSES TO MEASURE AND IMPROVE PATIENT EXPERIENCE: UNIVERSITY HOSPITAL – THE NEW “U”</strong></th>
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</thead>
<tbody>
<tr>
<td>University Hospital</td>
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<td>TPI - 136141205</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>136141205.3.12</td>
<td>3.1-6.1</td>
<td><strong>Percent improvement over baseline of patient satisfaction scores</strong></td>
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<thead>
<tr>
<th>Year (10/1/2012 – 9/30/2013)</th>
<th>Year (10/1/2013 – 9/30/2014)</th>
<th>Year (10/1/2014 – 9/30/2015)</th>
<th>Year (10/1/2015 – 9/30/2016)</th>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
</tr>
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</table>

**[P.2] Write and disseminate a patient/family experience strategic plan**

**Metric 1 [P-2.1]: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization.**

- **Baseline:** Currently there is no strategic plan that has been written or shared.
- **Goal:** to have plan written and disseminated to all senior leaders and middle managers.
- **Data Source:** The office of Patient-Centered Care documentation and NRC - Planetree Patient-Centered Care Improvement Guide

**Milestone 1 Estimated Incentive Payment:** $2,357,830

**[P-4] Integrate patient experience into employee training.**

**Metric 1- [P-4.1]: Percent of new employees who received patient experience training as part of their new employee orientation.**

- **Baseline:** Currently there is no patient centered care training for new employees.
- **Goal:** 100% training for all new hires into University Health System.
- **Data Source:** New Hire Packets, training and orientation documentation.

**Milestone 3 Estimated Incentive Payment:** $2,572,266

**[P-9]: Develop a plan to roll out a regular inquiry into patient experience in organizations currently without one, or for areas with one, in a new area of the organization which currently does not collect patient experience information.**

**Metric 1 [P-9.1]: Submission of a patient experience implementation and or expansion plan.**

- **Goal:** To write the plan for one FQHC provider to collect patient experience data from their patient population.
- **Data Source:** Office of Patient Satisfaction/ Office of Patient Centered Care and NRC Picker Survey tool.

**Milestone 5 Estimated Incentive Payment:**

**[I-16]: Improve patient satisfaction/experience scores.**

**Metric 1 [I-16.3]: Demonstrate an increase in performance relative to other providers in the same RHP, comparative with similar organization provider in other RHPs, and in contrast with state benchmark.**

- **Goal:** Improve scores by 2% over DY4 scores
- **Data Source:** NRC Picker

**Milestone 7 Estimated Incentive Payment:** $4,262,185
<table>
<thead>
<tr>
<th><strong>Milestone 2</strong></th>
<th><strong>Milestone 4</strong></th>
<th><strong>Milestone 6</strong></th>
</tr>
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<tbody>
<tr>
<td>[P-15]: Develop a training program on patient experience. Metric 2 [P-15.1]: Submission of training program materials. Baseline: Currently there is no program in place for training or educating staff on improving the patient experience. Goal: train 90% of the staff at University Health System on patient experience. Data Source: Training documentation and /Scanned employee ID data.</td>
<td>[P-8] Develop new methods of inquiry into patient and/or employee satisfaction, or improving the existing ones, to achieve greater quality and consistency of data. Metric 1 [P-8.1]: Develop a new patient experience tool or revise and improve the current one. Baseline/Goal: Currently patient satisfaction surveys are sent only by mail with 20% return. Data Source: NRC Picker Corp and office of Patient Relations/Office of Patient-Centered Care.</td>
<td>[I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families Metric 18-1: Number of organization-wide displays (can be physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: One virtual display about the organization’s performance in the area of patient/family experience per year via the UHS intranet; and yearly give an internal communication from the CEO of the health system on the experience improvement work throughout the health system. Data Source: Display and</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $2,357,830</td>
<td>Milestone 4 Estimated Incentive Payment: $2,572,266</td>
<td>$2,579,743.5</td>
</tr>
</tbody>
</table>
internal communication
Rationale/Evidence: Keeping the workforce informed on the progress of improvement efforts is key to developing an organization-wide ownership of the efforts.

Milestone 6 Estimated Incentive Payment: $2,579,743.5

| Year 2 Estimated Milestone Bundle Amount: $4,715,660 | Year 3 Estimated Milestone Bundle Amount: $5,144,532 | Year 4 Estimated Milestone Bundle Amount: $5,159,487 | Year 5 Estimated Milestone Bundle Amount: $4,262,185 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $19,281,864
Identifying Project and Provider Information:

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<th>Title: 2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency</th>
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<tbody>
<tr>
<td>Unique RHP ID#: 136141205.2.3 – PASS 1</td>
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<tr>
<td>Performing Provider: University Hospital</td>
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<td>Performing Provider TPI: 136141205</td>
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Project Summary:

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<thead>
<tr>
<th>Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.</th>
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</thead>
<tbody>
<tr>
<td>Intervention(s): This project will establish new operational standards within each department based on transparent key performance indicators (KPIs). Visual management boards will be designed specifically for each department so that staff, administration, physicians, and even patients can understand and be encouraged to evaluate the performance for a given department. There will also be a continued focus on training staff/providers on Lean Healthcare Methodologies.</td>
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<td>Need for the project: The National Strategy for Quality Improvement (developed under the Patient Protection and Affordable Care Act) has identified the current state of the American health care system as being highly fragmented due to poorly designed clinical care processes that has subsequently translated into unnecessary duplication of services, poor patient clinical care, and experience. As a result, the National Quality Strategy calls for health systems to deliver high quality, efficient, safe, patient-centered care.</td>
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<tr>
<td>Target population: The target population will include all UH patients and staff. Medicaid funded and uninsured patients comprise 62% of patients who receive services at UHS.</td>
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<td>Category 1 or 2 expected patient benefits: This project will implement a quality improvement initiative to improve inefficiencies and/or reduce program variation in DY2. A series of rapid improvement projects will be implemented as well as recruitment of quality improvement champions in DY3 and DY4 culminating in the completion of at least 60 process improvement events by DY5. Patients and staff will directly benefit from quality improvement methodologies including Lean that will help to identify waste in the system resulting in enhanced quality of care, more efficient processes, and standardization of procedures.</td>
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<tr>
<td>Category 3 outcomes:</td>
</tr>
<tr>
<td>3.IT.5.1 Percent improvement over baseline of cost savings</td>
</tr>
<tr>
<td>• DY4 – Demonstrate cost savings in care deliver by TBD% over established baseline.</td>
</tr>
<tr>
<td>• DY5 - Demonstrate cost savings in care deliver by TBD% over established baseline.</td>
</tr>
</tbody>
</table>
3.1T.6.1 Percent improvement over baseline of patient satisfaction scores

- **DY4** – Increase Patient Satisfaction Scores by TBD% over established baseline of patient satisfaction scores.
- **DY5** - Increase Patient Satisfaction Scores by TBD% over established baseline of patient satisfaction scores

**Project Description:**

The salience of making American healthcare more efficient and integrated was elevated by the passage of the Affordable Care Act (ACA). This in an era where the current state of health care delivery is considered to being highly fragmented due to poorly designed clinical care processes that has subsequently translated into unnecessary duplication of services, poor patient clinical care, and experience.

As part of an effort to enhance both quality care and the patient experience, University Health System will implement the Lean methodology to determine the use of materials and human resources, improve value to the patient, and distinguish how and why inputs into certain processes translate into value, and find ways to eliminate wasteful components.

University Health System’s Operational Excellence initiative will serve as the vehicle to drive continuous process improvement. Through application of the Lean methodology, staff will engage in problem solving techniques based on quantitative data aimed at improving day-to-day work processes that result in better patient care.

Target areas already identified are the surgical ICU, the discharge process, pharmacy, ED, and the OR. Projects include management excellence, patient throughput analysis, workflow improvement, and medication management.

**Goals and Relationship to Regional Goals**

The goal of this project is to establish new operational standards within each department based on transparent key performance indicators (KPIs). Visual management boards will be designed specifically for each department so that staff, administration, physicians, and even patients can understand and be encouraged to evaluate the performance for a given department.

**Project Goals:**

- Implement a quality improvement initiative to improve inefficiencies and/or reduce program variation.
- Implement a rapid improvement project using a proven methodology.
- Implement at least one patient care-centered process improvement project in the health system.

The project meets the following regional goals: CN. 1 – Improve quality of healthcare delivery and patient experience.

**Challenges:**
The primary challenge to this project will involve having the health system incorporate and adopt a new organizational ‘mindset’ that is focused on identifying and solving operational inefficiencies alongside intensive change management that is focused on improving processes that add value to patient care and experience.

Many processes are not centered on the patient but around antiquated workflows, physician preference and nurse preference. These have resulted in “workarounds” that have consequently lead to greater downstream inefficiencies resulting in disconnected and broken processes that introduce waste and diminish human potential. University Health System will progressively improve performance by evaluating human, process, and system performance to center around the patient’s overall health service experience.

Another challenge faced is the ability to collect data to sustain performance and measure success. Lean process improvement is metric and data driven and will create a more “date-driven” mindset. The health system will have to engineer new ways, either manual or automated, to gather data which grows are platform for data collection. The health system struggles with inconsistent data due to ineffective communication between the EMR and supporting programs. UH has adopted the “best of breed” approach with clinical programs. The health system has purchased specific operating suites for specific functions and has chosen not to stay uniform in vendor, where applicable. Monitoring data across multiple clinical departments will require increased awareness of its importance and diligence. UH will look into purchasing a project management program to keep data centralized and organized. Eventually, a comprehensive dashboard will be built to display a portfolio of all projects to track results on a global scale.

5-Year Expected Outcome for Provider and Patients

Through design, development and implementation of the Lean methodology, University Health System expects to see improvements in the quality and health service experience of its patients. Further, University Health System plans to have 30% of providers/staff educated in the Lean methodology, a total of 60 rapid process improvement events completed, and a culture that values taking initiative for continual problem solving. Expected outcomes related to project goals are described below.

**Starting Point/Baseline:**
Currently an orientation of the Lean methodology is underway at University Health System. University Health System will develop a new Lean department devoted to training staff to undertake performing process improvement within their respective areas. Therefore the starting point/baseline for implementing a program to improve inefficiencies and/or reduce program variation is 0 in DY2.

**Rationale:**
With roots in manufacturing, the Lean methodology requires all staff to be involved in helping to redesign processes to improve flow and reduce waste. Lean methodology also incorporates a patient focused approach by helping to identify and remove non-value added activities (waste), allowing more time for value added work (enhancing the patient experience of direct patient care). The rationale is to reduce variation in experience and treatment, focus more on quality and outcomes based on metrics and performance, and create a more efficient and satisfying working environment for staff and physicians. University Health System will also evaluate care patterns to find areas of underuse of services, overuse of services, misuse of services, and disparities in
quality of care delivered.

**Project Components**
The design and strategy of the proposed quality improvement process will be accomplished by meeting all required project components.

a. Provide training and orientation to the Lean methodology to clinical and administrative staff in order to elevate the importance of undertaking process improvement strategies, developing and utilizing metrics, methodologies, and culture change.

b. Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

c. Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination.

d. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.

e. Implement software to integrate workflows, performance metrics and provide real-time performance feedback.

f. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.

Unique Community Need Addressed:

Implementation of this quality process improvement methodology responds to unique community need CN. 1 – Improve quality of healthcare delivery and patient experience.

As stated previously University Health System is currently developing the Lean program to include visual management boards for departments. The will be designed around key performance indicators selected by departmental leadership, operational dashboards, quality of care performance measures for staff to quickly review and understand the performance of the department.

This level of transparency is new to University Health System and will guide our process improvement initiatives. Process improvement events will focus on improving workflows, processes, and policies to bring more value to the patient. Process improvement events will also drive higher quality to the patients. As University Health System reduces waste and redesigns processes to streamline each patient experience, it allows for clinicians to focus more on direct patient care instead of being deterred by inefficiencies within each process or system. Being the lowest ranked state on healthcare quality, University Health System, as a county hospital, should be a leader in system redesign that strengthens quality care for patients and advances efforts to become a high performing healthcare delivery system.
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>OD-5 Cost of Care</th>
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**IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery** *(standalone measure for 2.5 only. For all other projects – Non-standalone measure)*

- **a. Numerator:** Type of analysis to be determined by provider from following list: Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis
- **b. Data Source:** TBD by provider as appropriate for analysis type

**Reasons/Rational for Selecting the outcome measures:**
Lean process improvement initiatives will streamline processes. Part of reducing waste includes cost minimization because fewer resources are being devoted towards ‘non-value added’ activities. As processes are improved, employees will have more time to spend on value-added activities and focusing on maximizing the patient’s experience. There will be a reduction in the amount of time spent on inefficient or unnecessary steps in the process of caring for patients. Through the different type of cost studies, UH expects to see cost improvement in care delivery as Lean management philosophies are developed throughout the system. The process milestones for this category 3 outcome measure represent the build up to reaching the improvement target. Essentially, cost minimization adds value to the tax-paying citizens of Bexar county. As the county hospital, University Health System has a fiscal responsibility to use the resources given by the county as efficiently as possible. Lean process improvement focuses on reducing waste, one of which is unnecessary cost.

### OD-6 Patient Satisfaction

**IT-6.1 Percent improvement over baseline of patient satisfaction scores** *(all questions within a survey need to be answered to be a standalone measure)*

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
- (1) are getting timely care, appointments, and information; *(Standalone measure)*
- (2) how well their doctors communicate; *(Standalone measure)*
- (3) patient’s rating of doctor access to specialist; *(Standalone measure)*
- (4) patient’s involvement in shared decision making, and *(Standalone measure)*
- (5) patient’s overall health status/functional status. *(Standalone measure)*

- **a. Numerator:** Percent improvement in targeted patient satisfaction domain
- **b. Data Source:** Patient survey
- **c. Denominator:** Number of patients who were administered the survey

**Reasons/Rational for Selecting the outcome measures:**
The patient satisfaction outcome measure was selected due to its consideration as a valid self-report rating by the patient in regards to the quality of care received during their most recent appointment.
Further, the intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

With a service catchment area of 1.7 million residents, University Health System is the major safety-net hospital for Bexar County, Texas. Ensuring that timely, efficient, equitable, high quality care is delivered to the population will be strengthen by taking into account and measuring the patient perspective thus translating into better health for the community.

**Relationship to other Projects:**

The project’s emphasis on implementation of continuous, rapid process improvement will strengthen University Health System’s mission to achieve best care by becoming cost-effective and efficient further reinforces and enables the following projects.

**Category 1:**
(Project ID: 92414401.2.2) Expand Primary Care Capacity – Improvement in patient flow and reducing waste in process will provide more minutes in every day for value-added activity (patient care). University Health System could expand capacity through efficiency.

**Category 2:**
(Project ID: 136141205.2.1) Enhance/expand medical homes – Lean methodologies will help create the new processes in the medical home model.

(Project ID: 136141205.2.8) Conduct medication management – This area is already indentified as a target for rapid process improvement.

**Category 4:**
RD-4 Patient-centered Healthcare
1. **Patient Satisfaction**

The reporting of the measures must be limited to the inpatient setting only. All of the HCAHPS’ questions included for the themes listed below are required to be included in RHP plans for PPs required to report for DY 2-5, or if HCAHPS not in place in DY 2, starting DY 3.

a. Each HCAHPS theme includes a standard set of questions. The following HCAHPS’ themes will be reported on:
   - Your care from doctors;
   - Your care from nurses
   - The hospital environment;
   - When you left the hospital.

b. Data Source: HCAHPS296
Relationship to Other Performing Providers’ Projects in the RHP:

Other systems are leading similar projects to expand specialty care. Baptist Medical Center, Methodist Hospital, and Nix Health Care System are systems within San Antonio that have targeted this for improvement. Targeted areas may be similar across each hospital. In the spirit of the waiver, University Hospital will work in conjunction with these health systems as they are serving the same targeted population. University Health System will attempt to collaborate and learn from these partnering projects.

Plan for Learning Collaborative:

Operational Excellence will be based on best practices developed outside our region that could be effectively implemented in our region. Lean incorporates best practices and national benchmarks to measure success. Most of these identifiers are standardized across the country lending this project to:

- Developing a plan to communicate ideas, data, and successes across the region and state
- Stay current on best practices and benchmarks to adopt pertinent metrics to measure success
- Organize and participate in learning events across the RHP to invite experts to share knowledge regarding quality improvement and patient safety.

Project Valuation:

Achieves waiver goals:

This is aligned with the overall strategy of the waiver by improving the healthcare infrastructure to serve the patients of Bexar county and surrounding areas. As University Health System reduces waste and redesigns processes to streamline each patient experience, it allows for clinicians to focus more on direct patient care instead of being deterred by inefficiencies within each process or system. It further maintains and supports a more coordinated delivery system bringing value to the patient.

Addresses community needs:

This will address community need 1 (as defined by RHP 6): “Texas ranks last in the nation on healthcare quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.” The impact will be to improve the patient experience as they receive care in a culture of continuous improvement focused on value-added activities.

Project scope:

The outreach of this project is large scope as it will affect all patients entering our system. University Health System is creating a culture of Operational Excellence that will provide consistency for the patient in all interactions and across the continuum of care – from direct clinical care, to the registration process, to nursing units to discharge.

Project investment:

The investment is considered a strategic imperative that addresses the triple aim in health care and so therefore this program will be extensive simply due to the time investment of leadership, physicians, and staff. Rapid improvements, while extremely effective, take considerable amounts of concentrated time. University Health System will hire a Lean Director and a Lean Data Analyst to help facilitate the different projects involved, which is a financial commitment from the Health System.
<table>
<thead>
<tr>
<th>136141205.2.3 PASS 1</th>
<th>2.8.1</th>
<th>2.8.1 A-F</th>
<th>2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>University Hospital</strong></td>
<td><strong>TPI-136141205</strong></td>
<td><strong>Improved Cost Savings: demonstrate cost savings in care delivery</strong></td>
<td></td>
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<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>136141205.3.13</td>
<td>3.IT-5.1</td>
<td><strong>Percent Improvement over baseline of patient satisfaction scores</strong></td>
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<tr>
<td></td>
<td>136141205.3.14</td>
<td>3.IT-6.1</td>
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<tr>
<td><strong>Year 2 (10/1/2012 – 9/30/2013)</strong></td>
<td><strong>Year 3 (10/1/2013 – 9/30/2014)</strong></td>
<td><strong>Year 4 (10/1/2014 – 9/30/2015)</strong></td>
<td><strong>Year 5 (10/1/2015 – 9/30/2016)</strong></td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 4</strong></td>
<td><strong>Milestone 8</strong></td>
<td><strong>Milestone 11</strong></td>
</tr>
<tr>
<td>P-6 [Implement a program to improve inefficiencies and/or reduce program variation]</td>
<td>P-7 [Implement a rapid improvement project using a proven methodology]</td>
<td>P-5 [Complete a Kaizen assessment]</td>
<td>P-7 [Implement a rapid improvement project using a proven methodology]</td>
</tr>
<tr>
<td>Metric 1: P-6.1 Performance improvement events</td>
<td>Metric 1: P-7.1 Rapid improvement cycle</td>
<td>Metric 1: P-5.1 Implement at least one patient care centered process improvement project in the health system</td>
<td>Metric 1: P-7.1 Rapid improvement cycle</td>
</tr>
<tr>
<td>Baseline: 0</td>
<td>Baseline: 0</td>
<td>Baseline: DY3</td>
<td>Baseline: DY3</td>
</tr>
<tr>
<td>Goal: number of performance improvement events. Data Source: documentation of findings in improvement events</td>
<td>Goal: Perform 12 rapid improvement projects Data Source: Performing Provider report</td>
<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
<td>Goal: documentation of all steps in the cycle methodology were performed. Data Source: report of findings</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $1,286,133</td>
<td>Milestone 8 Estimated Incentive Payment: $1,719,829</td>
<td>Milestone 11 Estimated Incentive Payment: $1,420,728.33</td>
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<tr>
<td><strong>Milestone 2</strong></td>
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<tr>
<td>P-1 [Target specific workflows, processes and/or clinical areas to improve]</td>
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<tr>
<td>Metric 1: P-1.1 Performing Provider review and</td>
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<td><strong>Milestone 5</strong></td>
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<td>P-2 [Identify/target metric to measure impact of process improvement methodology and establish baseline]</td>
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<td>Metric 1: P-2.1 Identification of impact metrics and baseline Baseline: TBD</td>
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<td><strong>Milestone 6</strong></td>
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<td>P-3 [Complete a retrospective analysis of process improvement projects]</td>
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<tr>
<td>Metric 1: P-3.1 Analysis of process improvement project data Baseline: 0</td>
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<tr>
<td>Goal: Improve at least one process improvement project Data Source: report of findings</td>
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<td>Milestone 6 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 7</strong></td>
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<tr>
<td>P-4 [Implement a process improvement project using a proven methodology]</td>
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<td>Metric 1: P-4.1 Implementation of process improvement project Baseline: 0</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td>Milestone 7 Estimated Incentive Payment: $1,504,413.33</td>
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<td><strong>Milestone 8</strong></td>
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<tr>
<td>P-5 [Complete a Kaizen assessment]</td>
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<tr>
<td>Metric 1: P-5.1 Implement at least one patient care centered process improvement project in the health system</td>
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<td>Baseline: 0</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td>Milestone 8 Estimated Incentive Payment: $1,719,829</td>
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<td><strong>Milestone 9</strong></td>
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<tr>
<td>P-7 [Implement a rapid improvement project using a proven methodology]</td>
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<td>Metric 1: P-7.1 Rapid improvement cycle Baseline: TBD</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td>Milestone 9 Estimated Incentive Payment: $1,719,829</td>
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<td><strong>Milestone 10</strong></td>
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<tr>
<td>P-8 [Conduct a root cause analysis of process improvement projects]</td>
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<tr>
<td>Metric 1: P-8.1 Analysis of process improvement project data Baseline: TBD</td>
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<tr>
<td>Goal: identify root cause of at least one process improvement project Data Source: report of findings</td>
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<td>Milestone 10 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 11</strong></td>
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<td>P-9 [Implement a process improvement project using a proven methodology]</td>
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<td>Milestone 11 Estimated Incentive Payment: $1,420,728.33</td>
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<td>P-10 [Conduct a root cause analysis of process improvement projects]</td>
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<td>Goal: identify root cause of at least one process improvement project Data Source: report of findings</td>
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<tr>
<td>Milestone 12 Estimated Incentive Payment: $1,420,728.33</td>
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<tr>
<td><strong>Milestone 13</strong></td>
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<tr>
<td>P-11 [Evaluate process improvement project outcomes]</td>
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<tr>
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<tr>
<td>Milestone 13 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 14</strong></td>
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<tr>
<td>P-12 [Implement a process improvement project using a proven methodology]</td>
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<tr>
<td>Milestone 14 Estimated Incentive Payment: $1,420,728.33</td>
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<td><strong>Milestone 15</strong></td>
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<tr>
<td>P-13 [Conduct a root cause analysis of process improvement projects]</td>
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<td>Goal: identify root cause of at least one process improvement project Data Source: report of findings</td>
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<td>Milestone 15 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 16</strong></td>
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<tr>
<td>P-14 [Evaluate process improvement project outcomes]</td>
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<td>Metric 1: P-14.1 Evaluation of process improvement project outcomes Baseline: TBD</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td><strong>Milestone 17</strong></td>
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<tr>
<td>P-15 [Implement a process improvement project using a proven methodology]</td>
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<td>Metric 1: P-15.1 Implementation of process improvement project Baseline: TBD</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<tr>
<td>Milestone 17 Estimated Incentive Payment: $1,420,728.33</td>
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<tr>
<td><strong>Milestone 18</strong></td>
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<td>P-16 [Conduct a root cause analysis of process improvement projects]</td>
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<td>Metric 1: P-16.1 Analysis of process improvement project data Baseline: TBD</td>
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<td>Goal: identify root cause of at least one process improvement project Data Source: report of findings</td>
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<tr>
<td>Milestone 18 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 19</strong></td>
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<td>P-17 [Evaluate process improvement project outcomes]</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td>Milestone 19 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 20</strong></td>
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<td>P-18 [Implement a process improvement project using a proven methodology]</td>
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<td>Metric 1: P-18.1 Implementation of process improvement project Baseline: TBD</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td><strong>Milestone 21</strong></td>
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<td>P-19 [Conduct a root cause analysis of process improvement projects]</td>
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<td>Metric 1: P-19.1 Analysis of process improvement project data Baseline: TBD</td>
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<td>Goal: documentation of findings from process improvement project Data Source: report of findings</td>
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<td>Milestone 22 Estimated Incentive Payment: $1,499,408.33</td>
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<td><strong>Milestone 23</strong></td>
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<td>P-21 [Implement a process improvement project using a proven methodology]</td>
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<td>Metric 1: P-21.1 Implementation of process improvement project Baseline: TBD</td>
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<td><strong>Milestone 24</strong></td>
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<td>P-22 [Conduct a root cause analysis of process improvement projects]</td>
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<td>Metric 1: P-22.1 Analysis of process improvement project data Baseline: TBD</td>
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<td>P-23 [Evaluate process improvement project outcomes]</td>
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<td>Milestone 2</td>
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<tr>
<td>Priority:</td>
<td>select/define impact metrics and determine baseline.</td>
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<tr>
<td>Goal:</td>
<td>submit report.</td>
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<tr>
<td>Data Source:</td>
<td>meeting minutes.</td>
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<tr>
<td>Priority:</td>
<td>P-X [Hire process improvement personnel to support and manage the project(s)]</td>
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<tr>
<td>Metric 1:</td>
<td>P-X.1 Hire personnel.</td>
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<td>Baseline:</td>
<td>0</td>
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<tr>
<td>Goal:</td>
<td>develop job description and hire personnel.</td>
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<td>Data Source:</td>
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<tr>
<td>Priority:</td>
<td>I-15 [Increase number of process improvement champions]</td>
</tr>
<tr>
<td>Metric 1:</td>
<td>I-15.1 Number of designated quality champions.</td>
</tr>
<tr>
<td>Baseline:</td>
<td>DY3</td>
</tr>
<tr>
<td>Goal:</td>
<td>develop 10 quality champions over baseline (30 total).</td>
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<tr>
<td>Data Source:</td>
<td>Training records in PeopleSoft.</td>
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<tr>
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<th>Estimated Incentive Payment: $1,420,728.33</th>
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<tbody>
<tr>
<td>Priority:</td>
<td>P-15: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
</tr>
<tr>
<td>Metric 1: P-15.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 0 Goal: To conduct two seminars or meetings to promote collaborative learning in a year.</td>
<td>Metric 1: P-15.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 0 Goal: To conduct two seminars or meetings to promote collaborative learning in a year.</td>
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<tr>
<td>a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance improvement across all providers.</td>
<td>a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance improvement across all providers.</td>
</tr>
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</table>

Baseline: 0 Goal: develop 10 quality champions Data Source: Training records in PeopleSoft

Milestone 7 Estimated Incentive Payment: $1,286,133

Milestone 13 Estimated Incentive Payment: $1,420,728.33
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<th>Year 3 Estimated Milestone Bundle Amount: $5,144,532</th>
<th>Year 4 Estimated Milestone Bundle Amount: $5,159,487</th>
<th>Year 5 Estimated Milestone Bundle Amount: $4,262,185</th>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $19,281,864</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $19,281,864</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $19,281,864</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $19,281,864</td>
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**Identifying Project and Provider Information:**

| Title: 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Establish a Patient Care Navigation Program for University Health System |
| Unique RHP ID#: 136141205.2.4 – PASS 1 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

**Project Summary:**

| Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County. |
| Intervention(s): This project will establish a patient navigation model comprised of social workers and case managers within the ambulatory setting to enhance quality of care, and access to clinical and social support for medically complex patients. |
| Need for the project: The University Health System ambulatory network is comprised of regional developing patient-centered medical homes that are located in an area of the county where large segments of the population are economically underserved, uninsured and who have been diagnosed with multiple chronic health conditions. Medically complex patients in particular carry a higher burden of disease and require extensive care coordination support to ensure adherence to clinical preventive care and treatment. The proposed patient navigation model will enhance the system’s effort to redesign delivery of care in a manner that provides the right care in the right setting. |
| Target population: The target population will include the medically complex Medicaid funded and uninsured patients who comprise 62% of patients who receive services within the health system and who frequently utilize the emergency room. This segment of patient more often carry higher disease burden (clinical and behavioral) that with appropriately tailored patient-navigation interventions can benefit both in terms of access to appropriate clinical care and community resource support. |
| Category 1 or 2 expected patient benefits: Provision of patient navigation services tailored to medically complex patients will occur in DY2 to DY 4 resulting in a 15 percent reduction in EC utilization by patients enrolled in the patient navigation model by DY5. The secondary goals are to enhance care coordination and reduce overall emergency room visits, hospital admissions, and hospital readmissions. |
| Category 3 outcomes: 136141205.3.15 3.IT.9.2 ED appropriate utilization |

- **DY4** - Decrease ED visits by TBD% for targeted conditions
DY5 - Decrease ED visits by TBD% for targeted conditions.

Project Description:

2.9.1 - Implement and provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic and behavioral health conditions, cognitive impairments and disabilities, limited English proficiency, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

The project will work towards establishing and enhancing patient navigators consisting of social workers and case managers beyond acute care and within the emergency center and defined ambulatory clinics to support the patients within the region. The project will work as a support network and educational system to aid and facilitate patient activation and empowerment.

The emergency room is the front door of acute care today for patients without funding and thus, access to health services. A bigger challenge for University Health System is that many patients who are hospitalized and who frequent the EC are considered high users. Data is plentiful via Crimson and IDX, and cross continuum collaboration is beginning to occur but the challenge remains that due to limited access to ambulatory primary and specialty services, high volumes of patients continue to seek care in the EC and hospital.

Goals of this project will be to provide a programmatic approach encompassing but not limited to:

- Stakeholder engagement per setting
- Education
- Identification and individual:
  - social support
  - culturally competent care
  - alternative resources to EC and acute hospitalization

The navigation team will work diligently to provide seamless, coordinated, timely, and site specific care for the patients in the program. We will continuously review our program for effectiveness and will incorporate changes as needed. We will develop various dashboards to track our progress.

The secondary benefit to University Hospital will be future cost avoidance.

**Relationship to Regional Goals**

This project will further achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth.
**5 Year Expected Outcome for Provider and Patients:**
For patients identified and managed by the Patient Navigation/Care Coordination program, the goal is to decrease EC utilization by 15%.

**Starting Point/Baseline:**
Beginning in June 2012, the Department of Care Coordination added five RNs and four Social Workers to the Emergency Center for 24/7 coverage. University Hospital Emergency Department is a Level 1 Trauma Center with a 2012 volume of over 68,000 patient visits. Two RN case managers were initiated as a pilot in June, 2012, in two ambulatory settings. Four Social workers have been present and are centralized at the Robert B. Green Campus (the largest University Health System ambulatory site), providing telephonic support to other ambulatory clinics as needed. Initial reports have been run but baselines are still being defined for “high-utilizers.” Discussions are just beginning regarding possible tools for encounter captures in the EC and clinics via Allscripts, Care Coordination software. The baseline is 0 because it is still being defined.

**Rationale:**
This project was selected to significantly enhance the existing navigator/care coordination program that was established in mid 2012, as a means of expanding health care throughout the health continuum, reaching into the ED and out to other ambulatory settings and providers within the community. The expansion of the navigator/ Care Coordination program includes nurses, social workers, and other identified and trained healthcare workers who work collaboratively with clients/patients, and other healthcare workers to facilitate and coordinate care.

Through the Patient Navigation program, we propose to meet all required project components:

a. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b. Deploy innovative health care personnel, such as case managers/social workers, community health workers and others as patient navigators.

c. Connect patients to primary and preventative care.

d. Increase access for patients to care management and/or chronic care management, including education in chronic disease self-management.

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

This project specifically addresses CN.3 which states many residents of RHP 6 lack access to medical care due to high rates of un-insurance and healthcare provider shortages.
Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting

IT-9.2 ED appropriate utilization (Stand-alone measure)
  d. Reduce Emergency Department visits for targeted conditions
  e. Data Source: EMR/IDX/Crimson/Truven Health/Allscripts

Reasons/rationale for selecting the outcome measure:
A recent study conducted at a university tertiary health care facility showed that 15.8% of patients presenting to the emergency center for care had no emergent needs and were misusing the emergency center. Other studies have reported that non appropriate patients present to emergency centers due to lack of resources, access to care, or have a misunderstanding or are unaware of other resources available. Because the ED at University Health System continues to experience high patient visits, this project outcome was selected with the intent to respond to the individual patient need(s) and optimally, decrease misuse of emergency center visits and hospitalizations for patients whose needs can be addressed otherwise. Patients will be identified as high-utilizers of the Emergency Center and will be targeted for navigation services.

Relationship to other Projects:

The project has multiple inter-relatedness to other projects within the RHP:

A. 92414401.2.2 – Enhance/expand the medical home
   a. The Navigation Program will support the medical home by navigating the patients in need of additional resources, specialty care, and appropriate resource utilization. The intent of the program will be to facilitate care throughout the care continuum while appropriately utilizing University Hospital resources.

B. 92414401.2.1 – Expand chronic care management models
   a. The Navigation Program is a component of the Care Management Model; as patient are identified as needing additional resources or education, the navigation program will aid in facilitating the necessary care.

C. 136141205.2.5 – Use palliative care programs
   a. Navigation Services will be supporting a Palliative Care program through the Emergency Department as well as through the primary care clinics. The navigation program will aid in identifying patients in need of those resources.

Category 4 measures include emergency department in RD-5 and patient-centered healthcare, including patient satisfaction and medication management in RD-4

Relationship to Other Performing Providers’ Projects in the RHP:

Bluebonnet trails and University of Texas Health Science Center at San Antonio are planning to establish or expand upon patient navigations services. As project definitions evolve, it is anticipated that even though the term “navigators” implies different roles per populations identified, there remains opportunities to share lessons learned, ideas, etc.
Plan for Learning Collaborative:

University Health System is very interested in sharing best practices, lessons learned, and other ideas to improve patient navigation services. We will participate in face-to-face meetings and/or conference calls to regularly share data related to the efficacy of various practices along with lessons learned as we implement this program.

Project Valuation:

Via the system created to weigh all University Health System projects, this project was rated very high (18) due to the anticipated volume of patients touched who will receive case management and social services support. Cost avoidance is the anticipated end result secondary to a reduction of admissions and readmissions as well as a decrease in EC utilization. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>136141205.3.15</th>
<th>3.1T-9.2</th>
<th>ED Appropriate Utilization (Stand-Alone Measure)</th>
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<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<tr>
<td><strong>Milestone 1</strong> [P-X (QI)]: Designate and/or hire personnel or teams to support or manage the project and/or intervention. Metric 1: Increase the number of personnel to support or manage the project. Baseline: Director, 2 assistive personnel; EC: 5 case managers, 4 social workers; Ambulatory: 2 case managers; 4 Social workers Goal: Develop management infrastructure; Hire and train a manager, 3 additional case managers and 2 social</td>
<td><strong>Milestone 4</strong> [P-X (QI)]: Designate and/or hire personnel or teams to support or manage the project and/or intervention. Metric 1: Increase the number of personnel to support or manage the project. Baseline: Ambulatory: 5 case managers and 6 Social workers Goal: Hire and train 2 additional case managers and 2 social workers. Data Source: HR documents, training/meeting agendas.</td>
<td><strong>Milestone 7</strong> [P-3]: Provide navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of active patients enrolled in the program. Baseline: 75-100 Goal: Increase the case load to 100-125 active patients per region. Data Source: EMR/IDX/Allscripts</td>
<td><strong>Milestone 9</strong> [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified per clinic as ED frequent users. Goal: 15% reduction in high EC utilizers for patients assigned to program. Data Source: EMR/IDX/Allscripts/Crimson</td>
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<tr>
<td><strong>Milestone 4 Estimated</strong></td>
<td><strong>Milestone 4 Estimated</strong></td>
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**Milestone 2**  
[P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education  
**Metric 1 [P-2.1]:** Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.  
Baseline: 7 case managers and 4 social workers have been trained either for the EC or clinic settings  
Goal: Educate and train 100% of staff assigned to the navigation team  
Data Source: Sign In sheets, Employee Files – Training session or continuing education attended  

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<th>Milestone 5</th>
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**Milestone 5**  
[P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education  
**Metric 1 [P-2.1]:** Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.  
Baseline: 7 case managers and 4 social workers have been trained either for the EC or clinic settings  
Goal: Educate and train 100% of staff assigned to the navigation team  
Data Source: Sign In sheets, Employee Files – Training session or continuing education attended  

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<th>Milestone 8</th>
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**Tests of new ideas, practices, tools or solutions collected with simple, interim measurement systems, and based on self-reported data and sampling that is sufficient for the purposes of improvement.**  
**Metric [P-2.1 QI]:** Number of new ideas, practices, tools, or solutions tested by each provider.  
Baseline: 0  
Goal: Minimum of 1 new idea/practice/tool per week per Navigation Team  
Data Source: Allscripts  

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100% of staff assigned to the navigation team.
Data Source: Sign In sheets, Employee Files – Training session or continuing education attended

Milestone 2 Estimated Incentive Payment: $1,414,698

**Milestone 3**
[P-3]: Provide Care Management/Navigation services to targeted patients
Metric 1 [P-3.1]: Increase in the number patients or percent of targeted patients enrolled in the program.

Baseline: 0
Goal: Enroll 50 patients in navigation services.
Data Source: EMR/IDX/Allscripts

Milestone 3 Estimated Incentive Payment: $1,414,698

**Milestone 6**
[P-3]: Provide Care Management/Navigation services to targeted patients
Metric 1 [P-3.1]: Increase in the number patients or percent of targeted patients enrolled in the program.

Baseline: 0
Goal: Maintain an active case load of 75-100 patients per clinic site.
Data Source: EMR/IDX/Allscripts

Milestone 6 Estimated Incentive Payment: $1,543,359.67

| Year 2 Estimated Milestone Bundle Amount: $4,244,094 | Year 3 Estimated Milestone Bundle Amount: $4,630,079 | Year 4 Estimated Milestone Bundle Amount: $4,643,538 | Year 5 Estimated Milestone Bundle Amount: $3,835,966 |
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $17,353,677
Identifying Project and Provider Information:
Title: 2.10.1 Use a Palliative Care Programs to address patients with end-of-life decisions and care needs: Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service
Unique RHP ID#: 136141205.2.5 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty, and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): This project will increase the quality of palliative care services and expand education regarding palliative medicine among primary care providers at University Hospital. The project will improve the quality of life for patients and families facing serious illness through earlier advanced care planning, better communication, as well as improved pain and symptom management and coordination of care.

Need for the project: Currently, less than one-third of palliative medicine consultations occur early in the course of hospitalization (within 72 hours after admission) at University Hospital. Late consultation results in missed opportunities to improve pain and symptom management, to establish a relationship with patients and families, and to promote patient and family-centered goals that might prioritize comfort over aggressive therapy.

Target population: The target population comprises patients with life-threatening or chronic progressive illnesses who would benefit from palliative care services including those with cancer, brain injury, trauma, cardiovascular disease, dementia, COPD, cirrhosis, and end-stage renal disease. Medicaid funded and uninsured individuals represent 62% of the patient population served by the Health System.

Category 2 expected patient benefits: The project will provide training and education in palliative care services to over 150 primary care physicians by DY2, 300 by DY3, 360 by DY4, and 400 by DY5. The project will provide effective pain screening to over 158 patients by DY2, 319 by DY3, 382 by DY4, and 479 by DY5. Benefits to the patient population include an increased awareness and access to palliative care services and the standardization of effective screening tools that increase the quality of care and improve the patient experience.

Category 3 outcomes: IT-13.1; IT-13.2; IT-13.5. Provide comprehensive clinical assessments.
- **DY4**—Provide comprehensive clinical assessments, documentation of life sustaining preferences, and spiritual/religious concerns for at least 75% of eligible patients (479).
- **DY5**—Provide comprehensive clinical assessments, documentation of life sustaining preferences, and spiritual/religious concerns for at least 90% of eligible patients (574).
Project Description:

The purpose of implementing an expanded Palliative Care program within University Hospital is to provide access to comprehensive supportive care services for patients in Bexar County who are at risk for serious illness and to improve quality of life for patients and families facing serious illness through intensive communication, pain and symptom management, advanced care planning, and coordination of care. The high prevalence of chronic disease in the Bexar County and throughout RHP Region 6 results in patients with cancer and chronic progressive illness. University Hospital is implementing a Palliative Care program known as LIFE (Lifelong Intensive Family and Emotional) Care/Palliative Medicine. The LIFE Care/Palliative Medicine program seeks five-year expected outcomes that will serve to mend gaps in comprehensive supportive services for the most vulnerable patient populations including patients with cancer, brain injury, trauma, and chronic progressive illness such as diabetes, cardiovascular disease, dementia, COPD, cirrhosis, and end-stage renal disease. To meet the challenges of providing broad access to supportive services for these patient populations, the LIFE Care/Palliative Medicine program will build on existing resources while developing three interconnected and interdisciplinary service lines—inpatient care, outpatient care, and advanced care planning—with an emphasis on the following goals through quality improvement initiatives driven by data collected from the actual patient population: early identification, planning, and support for at-risk patients and families across University Health System facilities and beyond; enhanced assessment, management, and documentation of pain and other symptoms; increased patient safety through education and documentation related to coordination of care and safe uses of medications; improved patient outcomes including patient and family satisfaction, ICU and hospital mortality, hospital readmission, and hospice referral. Benefits to the patient population include increased awareness among providers and patients as well as better access to palliative care services and standardization of effective screening tools for pain and other needs. All of these initiatives will lead to improved continuity of care across settings, earlier and safer pain and symptom control, patient empowerment, increased access to sources of social and spiritual support, and higher patient and family satisfaction.

Starting Point/Baseline:

University Hospital started the inpatient and outpatient service lines for the LIFE Care/Palliative Medicine program in July 2011. The service is currently staffed by Hospice and Palliative Medicine Board Certified and Board Eligible (American Board of Internal Medicine) physicians and a Registered Nurse with advanced training in Palliative Care, as well as a dedicated Palliative Care Social Worker and Chaplain who joined during the spring and summer of 2012 respectively. During the calendar year 2012, the LIFE Care/Palliative Medicine program provided 638 inpatient consultations and over 120 outpatient clinic visits. Currently, education in Palliative Care for primary care providers is sorely lacking and education for physicians-in-training is neither systematic nor embraced as a central part of the core ACGME curriculum.

Rationale:

Palliative Care is an effective tool for meeting the needs of patient populations who are at risk for suffering and progressive illness. Hundreds of well-designed studies have demonstrated that
Palliative Care improves family satisfaction and patient quality of life while reducing symptom burden and costs associated with non-beneficial medical care. For this reason, many states are attempting to remedy the status quo through Palliative Care initiatives. Milestones and metrics for this project were selected according to the likelihood that they would promote awareness and access to supportive services, improve skills across the healthcare system, and ensure effective use of screening tools. Project Components (a) and (b) have been fulfilled during the first year of the LIFE Care/Palliative Medicine program through the following: development of a business case for a palliative care service and transitioning patients from the acute care setting into home care and hospice. Project Components (c) and (d) will be addressed through the implementation of a screening process regarding pain management as well as the implementation of quality improvement initiatives to identify project impacts, lessons learned, and key challenges associated with expansion of the project. Process Milestone 2.1 (Educate primary care specialties in Palliative Care) will be used for DY 2-5 and will engage clinicians and residents across primary care specialties. This strategy will allow the LIFE Care/Palliative Medicine team to focus on clinical care for patients with complex care needs while also influencing the next generation of practitioners. Improvement Milestone I-11.1 (Pain screening) will promote standardization of effective screening tools that improve safety and enhance patient experiences.

State report cards issued by the Center to Advance Palliative Care reveal that Texas improved from a “D” in 2007 to a “C” in 2011 as a result of more hospitals investing in palliative care services, University Hospital among them, but this still remains low.

This program addresses both Community Need CN.1 (poor health care quality) and Community Need CN.2 (high prevalence of chronic disease, including cancer) identified in the RHP 6 Community Needs Assessment. The LIFE Care/Palliative Medicine program was started in mid-2011, but continues to grow due to the demand for services. Analysis of an internally maintained database shows less than one-third of LIFE Care/Palliative Medicine consultations occur early in the course of hospitalization (within 72 hours after admission).

All of the patients who were consulted late in the course of hospitalization suffered from a set of comorbidities and acute conditions that were identifiable at the time of admission. Late consultation entails a missed opportunity to improve pain and symptom management, to establish a healthy rapport with patients and families, and to promote patient and family-centered goals that might include prioritizing comfort over survival-at-all-costs. When patients who received an inpatient LIFE Care/Palliative Medicine consultation are matched by diagnoses and severity of illness to patients who did not receive a consultation, a significant disparity is revealed: for every LIFE Care/Palliative Medicine consultation there are at least five equally ill and distressed patients and families who were not introduced to the LIFE Care/Palliative Medicine team.

**Related Category 3 Outcome Measure(s):**

For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, treatment preferences, and documentation of spiritual concerns) reflect some of the core quality measures needed to achieve excellence in patient care. These metrics also correlate

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with the selected Process and Improvement metrics. There is documented evidence of problems with hospital symptom management and continuity of care:

- 1 in 2 patients describe their hospital care as “suboptimal”\(^50\)
- 1 in 4 patients report inadequate treatment for pain and shortness of breath\(^51\)
- 1 in 3 families report inadequate emotional support\(^52\)
- 1 in 3 patients state they are poorly educated for pain and other symptom management after hospital discharge\(^53\)
- 1 in 3 patients are not provided plans for follow-care after hospital discharge\(^54\)
- Over 50% of deaths in America occur in the hospital setting.\(^55\)
- Over 70% of patients who die in the hospital were admitted to the hospital in the previous six months.\(^56\)
- Only 40% of public hospitals have access to Palliative Care specialists.\(^57\)
- About 33% of patients enrolled in hospice die within one week.\(^58\)

Improving access to LIFE Care/Palliative Medicine services involves implementation of a comprehensive supportive service that inevitably relies on changing the culture in which the service is practiced. Referring physicians and physicians-in-training need to understand and appreciate the role that Palliative Care can play in improving patient and family satisfaction, pain and other symptom management, and in promoting patient and family-centered care. Education of referring physicians, especially primary care physicians and physicians-in-training, can deepen the appreciation for supportive care. Education in Palliative Care can also promote best practices and broad patient access to competent delivery of basics in Palliative Care, such as the safe use of opioids, emotional and spiritual aspects of care, and ethical issues related to surrogate decision-making and withdrawing or withholding life-sustaining interventions.

**Relationship to other Projects:**

**136141205.1.2 Expand Primary Care Capacity:** Implementation of education for primary-care providers, expanded outpatient Palliative Care services, and advance care planning efforts will help to relieve the time and resource-intensive obligations that primary care clinics face when caring for seriously ill patients and their families. Enhanced knowledge about safe-prescribing practices and available resources such as hospice can help primary care physicians navigate more confidently through the plan of care for their most vulnerable patients.

**136141205.1.7 Enhance Interpretation Services and Culturally Competent Care:** Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring care delivery to meet patients’ social, cultural, and linguistic needs. Inpatient and outpatient Palliative Care services focuses on culturally competent communication among patients, families, and providers. Opportunities for patients and families to voice their questions and concerns, particularly during family meetings, are key elements of promoting education, understanding, and empowerment.

**92414401.2.2 Enhance/Expand Medical Homes:** Outpatient Palliative Care services staffed by


\(^{52}\) ibid.


\(^{54}\) ibid.


an interdisciplinary team that also provides supportive care during acute hospitalization and closely collaborates with primary care physicians and specialists such as oncologists and surgeons provide a genuine opportunity to support a medical home. The LIFE Care/Palliative Medicine team is tracking data related to patient encounters, hospitalizations and readmissions, and symptom management, all of which can be used to gauge the success of a supportive medical home model.

**92414401.2.1 Expand Chronic Care Management Models:** Chronic disease management interventions are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Outpatient Palliative Care helps promote continuity across settings and reduce medical errors by ensuring that patients with advanced illness are seen by Palliative Care specialists soon after hospital discharge or as needed when referred by other specialists such as cancer doctors or surgeons.

**136141205.2.2 Redesign to Improve Patient Experience:** The service lines for the LIFE Care program will improve how the patient experiences healthcare and the patient and family satisfaction with the care provided. Symptom management, communication, continuity of care, and respect for patient preferences are all primary targets for improved experiences.

**Related Category 4 measures include the following:**
- Potentially Preventable Admissions (RD-1)
- 30-Day Readmissions (RD-2)
- Patient-centered Healthcare (RD-4)

Advance care planning in patients with chronic progressive illness has been shown to improve patient and family satisfaction and is also likely to save medical costs by reducing the use of unnecessary medical treatments such as prolonged ICU stays at the end of life, and increase hospice utilization in patients with life-limiting illness.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The LIFE Care/Palliative Medicine project serves a similar population found in other parts of our RHP 6. We will attempt to collaborate on the progress, learn from our mutual projects, and support a learning collaboration should one be formed on this topic. An analysis of regional projects submitted for RHP 6 includes the selection of project options by multiple performing providers which are related to the aims of palliative care program. These include:

1.1 Expand Primary Care Capacity
1.2 Increase training of Primary Care Workforce
2.1 Enhance/Expand Medical Homes
2.2 Expand Chronic Care Management Models
2.4 Redesign to Improve Patient Experience

Additionally, another performing provider has chosen the Use of Palliative Care Programs among their submissions and will be part of a regional learning collaborative to network and share ideas, challenges, and success stories with partner institutions.

**92414401.1.1 Increase training of Primary Care Workforce:** Implementing and developing the LIFE Care/Palliative Medicine service at University Hospital will provide opportunities for primary care physicians-in-training to rotate with Palliative Care specialists and promote skills that will be increasingly important as the population ages.
Project Valuation:

University Hospital has valued this project through its ability to achieve the waiver goals, meet community needs, meet the level of required investment, and include the value of palliative care in the context of both the inpatient and outpatient setting. In 2011, University Health System cared for over 233,000 unique patients, including about 67,000 Emergency Center visits, 400,000 outpatient clinic visits, and 20,000 inpatient discharges. The primary inpatient facility in University Hospital, which operates 496 beds and will expand to about 750 beds when the new University Tower is completed in 2014. South and Central Texas have some of the nation’s highest rates of diabetes and obesity. University Hospital is a Level One Trauma Center, a world-renowned solid organ transplant center, and a referral center for a broad array of life-threatening conditions including metastatic cancer, end-stage renal disease, cirrhosis, heart failure, AIDS, and vascular disease. During the calendar year 2012, the LIFE Care/Palliative Medicine program provided 638 inpatient consultations and over 120 outpatient clinic visits. Preliminary analysis from an internal database reveals that 50% of these patients suffered from advanced cancer, 30% had brain injury or polytrauma, and 30% faced end-stage organ disease such renal failure and cirrhosis, with some overlap among these groups. The ultimate goal for the LIFE Care/Palliative Medicine program is to support as many patients as possible early in the course of their life-threatening or disabling illnesses. In order to maximize the reach and impact, referring health care providers in both the outpatient and inpatient settings must (1) be capable of delivering excellent primary palliative care and (2) know when and how to refer to specialty services. Education is essential to success for both of these practices. As of 2012, approximately 300 primary care attending physicians and 300 primary care residents work within University Health System. The LIFE Care/Palliative Medicine aims to develop a comprehensive and effective educational program for as many of these providers as possible. While curriculum development will require time and energy on the front end, a strategic and sustained educational program can potentially improve the lifelong practices of the current and next generations of physicians. The value of education for improved health outcomes cannot be overstated: education represents a commitment to transforming the culture while yielding an immediate and sustained ripple effect of improved patient satisfaction, continuity of care, safe use of medications, and meaningful use of resources for the hundreds of thousands of patients who seek care from University Health System each year. Education can also improve outcomes related to the delivery of specialty services. Currently, less than one-third of palliative medicine consultations occur early in the course of hospitalization (within 72 hours after admission) at University Hospital. Late consultation results in missed opportunities to improve pain and symptom management, to establish a relationship with patients and families, and to promote patient and family-centered goals that might prioritize comfort over aggressive therapy. Teaching residents when to ask for specialty support can foster a culture of early collaboration and consultation. Additionally, pain control is increasingly recognized as a primary outcome in hospital care and this project offers strategies for demonstrating improvement in this area. The Agency for Healthcare Research and Quality suggests that patient safety and satisfaction cannot be optimized in hospital-based care without first raising the bar for pain assessment. The authors note that the scope of the problem is vast: 62% of the 35 million discharges from U.S. hospitals...
include surgery or interventional procedures, and over 80% of these patients experience post-operative or procedural pain.\textsuperscript{59} These patients are at risk for adverse cardiac events, swings in blood sugar, the development of chronic pain and addiction, and psychological distress such as anxiety and sleeplessness. The American Academy of Pain Medicine also notes that patients who experience uncontrolled pain experience higher absenteeism and lost productivity, with an annual estimated cost of about $300 billion.\textsuperscript{60} By combining targeted education with specialty symptom and decision support, the LIFE Care/Palliative Medicine team will help to ensure that the University Health System achieves its stated mission of “promoting the good health of community by providing the highest quality of care” and “teaching the next generation of health professionals.” Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost-savings, improved quality of life, and even prolongation of life.\textsuperscript{61} One large multi-institutional study that matched patients by severity of illness (propensity scores) showed that inpatient Palliative Care consultation significantly reduced direct and variable costs.\textsuperscript{62} For patients who were discharged alive, Palliative Care consultation correlated with an adjusted net savings of $1,700 per admission. And for patients who died in the hospital, savings exceeded $4,900 per admission. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is included, the savings to the healthcare system are substantial. Those savings can be used to further improve and expand supportive care for all patients. At University Hospital, early analysis demonstrates similar cost-savings. One-hundred and seventy patients seen by the LIFE Care/Palliative Medicine team during a six month period were matched to about 9,000 patients with similar diagnoses and severity of illness. With conservative assumptions and excluding outliers, reduced direct and variable savings averaged $5,600 per admission. Consultations performed within 72 hours of admissions yielded an even higher cost-savings of $12,600 per admission, which further illustrates the need for early Palliative Care consultation. For the 638 consults performed in 2012, the estimated cost-savings exceeded $5 million. Opportunity costs not included in this analysis includes ICU bed days, which also decreased by an average of one day per admission and likely resulted in reduced ICU mortality and better Emergency Center throughput. Early palliative care involvement is the goal, which offers the greatest ability to improve health outcomes, patient experience, and cost avoidance. The project offers a synergistic strategy for optimizing local clinical practice guidelines through palliative care education for primary care physicians, pain screening for all palliative care patients, optimized pain management, documentation of life sustaining preferences and religious/spiritual concerns.


### Related Category 3

**Outcome**

**Measure(s):**

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<thead>
<tr>
<th>136141205.2.5</th>
<th>2.10.1</th>
<th>2.10.1 C - D</th>
<th>2.10.1 Use a Palliative Care Program to address patients with end-of-life decisions and care needs: Lifelong Emotional (L.I.F.E.) Care/Palliative Medicine Service</th>
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<tbody>
<tr>
<td>University Hospital</td>
<td>TPI - 136141205</td>
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<tr>
<td>Pain assessment</td>
<td>Treatment Preferences</td>
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<tr>
<td>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**

Educate primary care specialties (family medicine, internal medicine, pediatrics, geriatrics, and other IM specialties) in providing palliative care including non-cancer training – P-2

**Metric 1:** Primary care specialties training and education in palliative care P-2.1:

- **Baseline:** Number of primary care specialty physicians educated in palliative medicine = 0
- **Goal:** Provide education to at least 25% of primary care specialty physicians (150).
- **Data Source:** Database that tracks type and number of training and education sessions by health

**Milestone 3**

Educate primary care specialties (family medicine, internal medicine, pediatrics, geriatrics, and other IM specialties) in providing palliative care including non-cancer training – P-2

**Metric 1:** Primary care specialties training and education in palliative care P-2.1:

- **Baseline:** Number of primary care specialty physicians at the beginning of DY3
- **Goal:** Provide education to at least 50% of primary care specialty physicians (300).

**Milestone 5**

Educate primary care specialties (family medicine, internal medicine, pediatrics, geriatrics, and other IM specialties) in providing palliative care including non-cancer training – P-2

**Metric 1:** Primary care specialties training and education in palliative care P-2.1:

- **Baseline:** Number of primary care specialty physicians at the beginning of DY4
- **Goal:** Provide education to at least 60% of primary care specialty physicians (360).

**Milestone 7**

Educate primary care specialties (family medicine, internal medicine, pediatrics, geriatrics, and other IM specialties) in providing palliative care including non-cancer training – P-2

**Metric 1:** Primary care specialties training and education in palliative care P-2.1:

- **Baseline:** Number of primary care specialty physicians at the beginning of DY5
- **Goal:** Provide education to at least 75% of primary care specialty attending
<table>
<thead>
<tr>
<th><strong>Milestone 1</strong></th>
<th><strong>Milestone 2</strong></th>
<th><strong>Milestone 3</strong></th>
<th><strong>Milestone 4</strong></th>
<th><strong>Milestone 5</strong></th>
<th><strong>Milestone 6</strong></th>
<th><strong>Milestone 7</strong></th>
<th><strong>Milestone 8</strong></th>
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<tbody>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $2,004,155.50</td>
<td>Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11</td>
<td><strong>Estimated Incentive Payment:</strong> $2,186,426</td>
<td><strong>Estimated Incentive Payment:</strong> $2,192,782</td>
<td><strong>Estimated Incentive Payment:</strong> $2,192,782</td>
<td>Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11</td>
<td><strong>Estimated Incentive Payment:</strong> $1,811,428.50</td>
<td>Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation or palliative care initial encounter. I-11.1:</td>
<td><strong>Baseline:</strong> Since start of palliative medicine program no data have been collected to establish a baseline, however, EHR documents have been created to document a comprehensive palliative medicine initial encounter including pain evaluation. <strong>Goal:</strong> Provide documented screening to at least 25% of all patients receiving a palliative care consult in DY2 (158). <strong>Formula:</strong></td>
<td><strong>Baseline:</strong> Number of patients receiving a palliative care consult in DY2</td>
<td><strong>Goal:</strong> Provide screening to at least 25% of palliative care patients (319). <strong>Formula:</strong></td>
<td><strong>Baseline:</strong> Number of patients receiving a palliative care consult in DY3</td>
<td><strong>Goal:</strong> Provide screening to at least 50% of palliative care patients (382). <strong>Formula:</strong></td>
<td></td>
<td><strong>Baseline:</strong> Baseline: Number of patients receiving a palliative care consult in DY4</td>
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<tr>
<td><strong>Data Source:</strong> Database that tracks type and number of training and education sessions by health professional category.</td>
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**Data Source:** Database that tracks type and number of training and education sessions by health professional category.

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**Metric 1:** Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation or palliative care initial encounter. I-11.1:

**Baseline:** Since start of palliative medicine program no data have been collected to establish a baseline, however, EHR documents have been created to document a comprehensive palliative medicine initial encounter including pain evaluation.

**Goal:** Provide documented screening to at least 25% of all patients receiving a palliative care consult in DY2 (158).

**Formula:**

Numerator: Patients who are screened for the presence or absence of pain (and if present, physicians (400)).

Data Source: Database that tracks type and number of training and education sessions by health professional category.

**Milestone 3**

**Estimated Incentive Payment:** $2,186,426

**Milestone 4**

Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11

**Metric 1:** Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation or palliative care initial encounter. I-11.1:

**Baseline:** Number of patients receiving a palliative care consult in DY2

**Goal:** Provide screening to at least 25% of palliative care patients (319).

**Formula:**

Numerator: Patients who are screened for the presence or absence of pain (and if present, physicians (400)).

Data Source: Database that tracks type and number of training and education sessions by health professional category.

**Milestone 5**

**Estimated Incentive Payment:** $2,192,782

**Milestone 6**

Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11

**Metric 1:** Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation or palliative care initial encounter. I-11.1:

**Baseline:** Number of patients receiving a palliative care consult in DY3

**Goal:** Provide screening to at least 50% of palliative care patients (382).

**Formula:**

Numerator: Patients who are screened for the presence or absence of pain (and if present, physicians (400)).

Data Source: Database that tracks type and number of training and education sessions by health professional category.

**Milestone 7**

**Estimated Incentive Payment:** $1,811,428.50

**Milestone 8**

Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care – I-11

**Metric 1:** Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation or palliative care initial encounter. I-11.1:

**Baseline:** Baseline: Number of patients receiving a palliative care consult in DY4

**Goal:** Provide screening to at least 75% of palliative care patients (479).

**Formula:**

Numerator: Patients who are screened for the presence or absence of pain (and if present, physicians (400)).

Data Source: Database that tracks type and number of training and education sessions by health professional category.
present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.

**Denominator:** Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.

**Exclusion:** Patients with length of stay 7 days in hospice or 1 day in palliative care.

**Data Source:** Electronic Health Record and Palliative Care Database.

<table>
<thead>
<tr>
<th>Milestone 2 Estimated Incentive Payment: $2,004,155.50</th>
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<tbody>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $2,186,426</td>
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<tr>
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<td>Milestone 8 Estimated Incentive Payment: $1,811,428.50</td>
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<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $4,008,311</th>
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<tr>
<td>Year 3 Estimated Milestone Bundle Amount: $4,372,852</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $4,385,564</td>
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<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $3,622,857</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,389,584**
**Identifying Project and Provider Information:**

**Title:** 2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammograms, immunizations): UHS Preventive Screening Program  
**Unique RHP ID#:** 136141205.2.7 – PASS 2  
**Performing Provider:** University Hospital  
**Performing Provider TPI:** 136141205

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**Project Summary:**

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

**Intervention(s):** The Health System will enhance access to evidence-based preventive screenings for the residents of Bexar County, Texas by working with regional providers, health centers and community-based organizations to collaborate, coordinate and establish a strategy that encourages adherence to cancer prevention screening in under and uninsured segments of the population. The outlined intervention also directly responds to the Health System’s Triple Aim Plus objectives of improving access across the care continuum, quality and outcomes, efficiency and patient experience. **Need for the project:** In Texas, cancer remains the leading cause of cancer death for persons 85 years of age and younger. Screening and early detection continues to be the most effective method of reducing cancer mortality. In South Texas (Public Health Service Region 8), prevalence data indicates that only 67% of women age 40 and older have had a mammogram within the past two years, 74% of adult females reporting having a cervical screening within the past three years and 66% of adults ages 50 and older report ever having a Sigmoidoscopy or Colonoscopy. For example, while the overall average annual age-adjusted incidence and mortality rates per 100,000 for breast cancer for women in this region is slightly lower (113.1 and 20.8) than the rest of Texas (115.5 and 22.2, respectively), among Hispanic females both the incidence (98.3) and mortality (18.1) associated with breast cancer is higher when compared to Hispanic females living in the rest of the state (92.7 and 17.1, respectively). Therefore, despite the benefits of screening, economically vulnerable and uninsured and minority populations are less likely to be screened and therefore at risk for cancer.

The demand for primary care visits in the Health System’s service area has been growing at a rapid rate. This is also occurring in areas where a majority of low-income, under and uninsured residents are concentrated in sectors where access to primary care and social services are limited. The rate of uninsured in Bexar County is 23%, highlighting the need for increased access. In addition, access to timely clinical preventive screenings can prevent and detect illnesses and diseases in their earlier, more treatable stages, which can lead to reduced risk of illness, disability, early death, and medical care costs.

**Target population:** This project will focus on reaching various segments of eligible patients (i.e.,
economically underserved, uninsured, or working women) through screening/health education events held at community, workplace, and faith-based venues.

**Category 1 or 2 expected patient benefits:** The anticipated 5 year goal is to increase the number of individual that are screened through this innovative evidence-based program by 20% over baseline (or 6,029 individuals). The secondary goal is to support coordination of services that improve timely access related evidence-based cancer prevention screening (breast, cervical, colorectal).

**Category 3 outcomes:** IT-12.1 (Breast Cancer Screening), IT-12.2 (Cervical Screening) IT-12.2 (Colorectal Screening). **DY4 –** Increase number of eligible individuals who receive a preventive screening by TBD% from established baseline of DY 2; **DY5 –** Increase number of eligible individuals who receive a preventive screening by TBD% from established baseline of DY2

**Project Description:**

In Texas, cancer remains the leading cause of cancer death for persons 85 years of age and younger. Screening and early detection continues to be the most effective method of reducing cancer mortality. In South Texas (Public Health Service Region 8), prevalence data indicates that only 67% of women ages 40 and older have had a mammogram within the past two years, 74% of adult females reporting having a cervical screening with the past three years and 66% of adults ages 50 and older report ever having a Sigmoidoscopy or Colonoscopy. For example, while the overall average annual age-adjusted incidence and mortality rates per 100,000 for breast cancer for women in this region is slightly lower (113.1 and 20.8) than the rest of Texas (115.5 and 22.2, respectively), among Hispanic females both the incidence (98.3) and mortality (18.1) associated with breast cancer is higher when compared to Hispanic females living in the rest of the state (92.7 and 17.1, respectively). Therefore, despite the benefits of screening, economically vulnerable and uninsured and minority populations are less likely to be screened and therefore at greater risk for cancer.

The project will be to implement an innovative community-based intervention model to increase access to clinical preventive services throughout Bexar County, Texas. The primary objective will be to encourage regional providers, health centers and community-based organizations to collaborate and coordinate on cancer prevention approaches that will focus on reaching various segments of eligible patients (i.e., economically underserved, uninsured, or working women) through screening/health education events held at community, workplace, and faith-based venues.

Through this process vulnerable/uninsured or underinsured populations in need of evidence-based preventive screening will be referred to low-cost or free mammograms, cervical screenings and or colorectal screenings. Breast Health Services provides screening and diagnostic follow-up in women 40 years of age and older as well as women referred with a need for diagnostics who reside in economically underserved areas of Bexar County, Texas. Access to preventive screenings (cervical cancer screening, colorectal cancer screening) will be made possible through the introduction of a mobile mammography unit alongside patient navigation services and development of a coalition of community-based cancer prevention, screening and treatment partners located within the proposed target service area.

The project’s goal of implementing evidence-based strategies that address chronic disease risk and thereby increase delivery of clinical preventive services for targeted populations (e.g.,
mammography, cervical and colorectal screens, blood pressure, and immunizations, etc.) firmly coincide with national and regional health improvement goals (Healthy People 2020, Bexar County Community Health Improvement Plan, 2012). These goals aim to improve delivery of evidence-based clinical preventive services that consist of screening and immunizations that can prevent diseases and reduce mortality associated with chronic disease.

Advancement in health information technology alongside standardized documentation procedures provide clinical staff a much more accurate and updated profile in the delivery of clinical preventive services to patients. Therefore, project goals will be to implement and expand evidence-based population-focused interventions as outlined in published studies and reports that include the United States Preventive Taskforce Guide to Clinical Preventive Services and the National Prevention Council’s National Prevention Strategy. These clinical recommendations make evident the importance of enhancing access to clinical and preventive care and thereby create opportunities that engage and motivate individuals to make informed decisions about their health that include seeking and adhering to clinical preventive care. This includes utilizing technology to inform patients that they are due for a preventive health service through clinical reminder systems (e.g., electronic health records with reminders or cues, chart stickers, vital signs stamps, medical record flow sheets) for preventive services.

The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaborative to be established.

Potential challenges faced by this project include ensuring access and delivery to clinical preventive screening to populations that are often confined by their socioeconomic position and therefore must navigate interpersonal, financial and geographic barriers to care. Another important element that providers consider a challenge is ensuring that resources are available to ensure treatment options for individuals who are diagnosed. Countermeasures to these challenges include implementing a culturally tailored patient navigation model that helps to ensure that barriers to seeking preventive care are reduced. Geographic barriers to care will be countered through expansion of mobile screening services that will target high economically distressed areas of the city. Further funding for treatment options will be strengthened by ensuring that patients are appropriately navigated into treatment.

**Relationship to Regional Goals:** This new project will further achievement of the regional goals of the Triple Aim; improve health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce health disparities by improving access to delivery of clinical preventive services (screening and immunizations); further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth.

Five year expected outcomes include having an established mobile screening services program that strengthens patient-centered care and addresses the triple aim of health service delivery performance that includes improving the experience and quality of care, improving population health and delivering care in cost-effective manner.
Starting Point/Baseline:
The current baseline for cancer-related screening as of October 1, 2012 is:
Breast Cancer Screenings: 14,000
Cervical Cancer Screenings: 12,000

1,748 preventive screenings as of September 30, 2012.

Rationale:
Almost half of all Americans (or 133 million) suffer from at least one chronic health condition including heart disease, stroke, hypertension and diabetes. An estimated 57 million individuals of working-age (age 18 to 64) live with at least one chronic disease. Cumulatively, chronic diseases remain the leading causes of death (70%) in the United States; claim the lives of 1.7 million Americans each year and cost the U.S. economy $1.3 trillion and are expected to reach $6 trillion by the year 2050.

Further, less than half of all Americans receive the recommended levels of screening associated with clinical preventive care. Studies confirm the clinical and economic benefits of providing timely access to preventive services by significantly reducing the onset of chronic health conditions such diabetes, infectious disease such as flu and pneumonia and detecting cancer and other diseases at much earlier stages. In Bexar County, Texas, 22% of residents live at or below the poverty level ($22,557), 17% receive no medical care due to cost, and 21% have no form of health insurance coverage with a diabetes incidence that it twice the national average (14%).

This project specifically addresses community need identification number two (CN.2): Address the high prevalence of chronic disease and related health disparities in the community through greater prevention efforts that focus on addressing chronic disease.

The proposed model provides the opportunity to redesign delivery of health services at UHS. This project represents an effort to expand University Health System’s patient-centered medical home by providing care in the right setting and at the right time for patients who historically have been unable to access clinical preventive care, by providing earlier detection and treatment and potential cost avoidance of unnecessary hospitalizations and/or ER visits due to preventable conditions that include screening for receipt of clinical preventive care.

Related Category 3 Outcome Measure(s):

**IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)**

a) Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.

b) Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded

c) Data Source: EHR, Claims, Visit management system

d) Rationale/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting
early preclinical disease when treatment may be easier and more effective. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a Category 1 Infrastructure Development screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

**IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)**

a) Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.
b) Denominator: Women aged 21 to 64 in the patient or target population.
c) Women who have had a complete hysterectomy with no residual cervix are excluded.
d) Data Source: EHR, Claims, Visit management system
e) Rationale/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

**IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)**

a) Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
b) Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.
c) Data Source: EHR, Claims, Visit management system
d) Rationale/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.
Relationship to other Projects:

This project is related to several other projects within the RHP plan:

92414401.2.2 Enhance/Expand Medical Homes
Increasing access to primary care will give patient access to other specialty and preventive services offered in the medical homes

92414401.1.1 (CMA) Expand training of the primary care workforce
Training future providers in primary will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

136141205.2.2 Redesign to Improve Patient Experience
Providing the ability to access healthcare in a timely manner and in locations where services are needed will lead to a better patient experience.

Related Category 4 measures include RD-4, patient-centered healthcare, including patient satisfaction and medication management and RD-3 potentially preventable complications.

Relationship to Other Performing Providers’ Projects in the RHP:

N/A

Plan for Learning Collaborative:

This project lends itself to participation in learning collaborative as other Performing Providers in RHP6 seek to develop and expand clinical preventive services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve preventive services.

Project Valuation:

1. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

2. This project addresses community needs by improving quality of healthcare delivery and patient experience, enhancing access to health services and expanding clinical preventive efforts.

3. The scope of this project is large in that it includes expansion across the 14 school districts in Bexar County, Texas and is critical to ensuring a healthy population (children, adolescents, caregivers and the surrounding areas).

4. This project requires a large investment in terms of personnel, technology and
infrastructure to ensure a coordinated approach to clinical preventive cases taken across the service catchment of area of 1.7 million residents. The hardware, software applications, human resources and time elements required to implement this project are of the highest organizational priority for UHS which is to ensure timely receipt of screening and clinical preventive care to economically underserved populations in Bexar County, Texas.
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<th>Year 5</th>
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**Milestone 1**
**P-1:** Development of innovative evidence-based project for target population.
**Metric 1 [P-1.1]:** [Documentation of innovational health service strategy/plan]
- Baseline: [N/A]
- Goal: Develop innovative/evidence-based health service intervention addressing improvement in clinical preventive care.
- Data Source: Documentation on innovational health service plan.

**Milestone 4**
**P-2:** Implement innovative evidence-based project for target population.
**Metric 1 [P-2.1]:** [Documentation of innovative health service strategy and testing outcomes]
- Baseline: [N/A]
- Goal: Implement an innovative patient-centered mobile preventive screening program that incorporates patient navigation, education with delivery of services that are held on-site and focus on community, workplace, and faith-based venues.
- Data Source: Documentation of implemented innovative health service plan in target population.

**Milestone 8**
**I-5:** Identify 1,400 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
**Metric 1 [I-5.1]:** [Number of individuals from target population that received breast cancer screening through innovative health service intervention consistent with evidence-based model]
- Baseline: Baseline year of October 1, 2012 to September 30, 2013 (14,000) Total number of unique individuals from target population reached by project.
- Goal: Increase

**Milestone 11**
**I-5:** Identify 2,100 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
**Metric 1 [I-5.1]:** [Number of individuals from target population that received breast cancer screening through innovative health service intervention consistent with evidence-based model]
- Baseline: Baseline year of October 1, 2012 to September 30, 2013 (14,000) Total number of unique individuals from target population reached by project.
- Goal: Increase
Metric 1 [P-2.1]: [Documentation of innovative health service strategy and testing outcomes]
  Baseline: [N/A]
  Goal: Implement innovative/evidence-based health service intervention addressing improvement in clinical preventive care.
  Data Source: Documentation of implemented innovational health service plan in target population.

Milestone 2 Estimated Incentive Payment: $979,965

Milestone 3
P-4: Execution of evaluation process for project innovation.
Metric 1 [P-4.1]: [Document evaluative process, tools and analytics.]
  Baseline: [N/A]
  Goal: Documentation of data collection tools and methodology.
  Data Source: Documentation on evaluation of project.

Milestone 3 Estimated Incentive Payment: $979,965

Milestone 4 Estimated Incentive Payment: $803,046.25

**Milestone 5**
I-5: Identify 700 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
Metric 1 [I-5.1]: [Number of individuals from target population that received breast cancer screening through innovative health service intervention consistent with evidence-based model]
  Baseline: Baseline year of October 1, 2012 to September 30, 2013 (14,000) Total number of unique individuals from target population reached by project. Goal: Increase by 5% from baseline.
  Data Source: EMR, IDX

Milestone 5 Estimated Incentive Payment: $803,046.25

Milestone 6
I-5: Identify 600 patients in

by 10% from baseline.
Data Source: EMR, IDX

Milestone 8 Estimated Incentive Payment: $1,077,650

**Milestone 9**
I-5: Identify 1,200 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
Metric 1 [I-5.1]: [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model]
  Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 10% from baseline.
  Data Source: EMR, IDX

Milestone 9 Estimated Incentive Payment: $889,152

**Milestone 10**
I-5: Identify 600 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
Metric 1 [I-5.1]: [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model]
  Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 15% from baseline.
  Data Source: EMR,IDX

Milestone 10 Estimated Incentive Payment: $1,077,650

**Milestone 11**
I-5: Identify 1,200 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
Metric 1 [I-5.1]: [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model]
  Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 15% from baseline.
  Data Source: EMR, IDX

Milestone 11 Estimated Incentive Payment: $889,152

**Milestone 12**
I-5: Identify 1,800 patients in defined population receiving innovative screening intervention consistent with evidence-based model.
Metric 1 [I-5.1]: [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model]
  Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 15% from baseline.
  Data Source: EMR, IDX

Milestone 12 Estimated Incentive Payment: $1,077,650

Milestone 9 Estimated Incentive Payment: $889,152
| Metric 1 [I-5.1]: | [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model] Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 5% from baseline. **Data Source:** EMR, IDX |
| Milestone 6 Estimated Incentive Payment: $803,046.25 |

| Milestone 7 |
| I-5: Identify 15 patients in defined population receiving innovative screening intervention consistent with evidence-based model. **Metric 1 [I-5.1]:** [Number of individuals from target population that received cervical cancer screening through innovative health service intervention consistent with evidence-based model] Baseline: Baseline year of October 1, 2012 to September 30, 2013 (12,000) Total number of unique individuals from target population reached by project. Goal: Increase by 5% from baseline. **Data Source:** EMR, IDX |
| Milestone 6 Estimated Incentive Payment: $803,046.25 |

| Milestone 10 |
| I-5: Identify 30 patients in defined population receiving innovative screening intervention consistent with evidence-based model. **Metric 1 [I-5.1]:** [Number of individuals from target population that received colorectal cancer screening through innovative health service intervention consistent with evidence-based model] Baseline: Baseline year of October 1, 2012 to September 30, 2013 (300) Total number of unique individuals from target population reached by project. Goal: Increase by 10% from baseline. **Data Source:** EMR, IDX |
| Milestone 10 Estimated Incentive Payment: $1,077,650 |

| Milestone 12 Estimated Incentive Payment: $889,152 |

| Milestone 13 |
| I-5: Identify 45 patients in defined population receiving innovative screening intervention consistent with evidence-based model. **Metric 1 [I-5.1]:** [Number of individuals from target population that received colorectal cancer screening through innovative health service intervention consistent with evidence-based model] Baseline: Baseline year of October 1, 2012 to September 30, 2013 (300) Total number of unique individuals from target population reached by project. Goal: Increase by 15% from baseline. **Data Source:** EMR, IDX |
| Milestone 13 Estimated Incentive Payment: $1,077,650 |
population that received colorectal cancer screening through innovative health service intervention consistent with evidence-based model. Baseline: Baseline year of October 1, 2012 to September 30, 2013 (300) Total number of unique individuals from target population reached by project. Goal: Increase by 5% from baseline. Data Source: EMR, IDX

Milestone 7 Estimated Incentive Payment: $803,046.25

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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $12,052,487**
Identifying Project and Provider Information:

Title: 2.11.2 Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors: University Hospital
Unique RHP ID#: 136141205.2.8 – PASS 2
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Project Summary:

Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty, the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): The program will provide access to a clinical pharmacist in the ambulatory setting/medical home during the medical consult. This pharmacist will be dedicated to the provision of education and medication management for patients with chronic diseases (ambulatory care sensitive conditions) who are on multiple medications and whose disease process is not well controlled and/or patients who utilize the Emergency Department or are hospitalized for their chronic disease.

Need for the project: The University Health System dispenses approximately 800,000 outpatient prescriptions per year to the uninsured and Medicaid patients who utilize the Health System for their health care needs. Although patients have access to medications they often lack understanding of the importance of complying with the prescribed regimen or how their drugs, food and home remedies interact. It is believed that additional time spent with the higher risk patients will improve the health of the patient and reduce unnecessary expenses including visits to the Emergency Department and hospitalizations.

Target population: The target population will be patients who are on multiple drug regimens with a history of non-adherence to medication as reflected by the lack of progression in the improvement of their chronic disease, and those who have multiple emergency department visits/hospitalizations related to their chronic disease. The target population will include the Medicaid funded and uninsured patients who comprise 62% of patients who receive services within the Health System.

Category 1 or 2 expected patient benefits: Improves access to pharmacist counseling. Patient benefit is to increase the number of patients accessing the service by 10% over baseline for DY3, and then 10% each year over the previous year through DY5. These efforts will provide the opportunity to tailor medication education for patients and will benefit their healthcare experience through the provision of safe, timely and effective patient-centered care relative to their medications.

Category 3 outcomes: 136141205.3.24 3.IT.2.11 total acute care hospitalizations for ambulatory care sensitive conditions
Project Description:

University Health System (Health System) provides care primarily to the uninsured and Medicaid populations of Bexar County. In this role the Health System provides (1) outpatient pharmacy services for patients discharged from the hospital to ensure that regardless of funding source, the needed medications are available at discharge, and (2) ongoing outpatient pharmacy services. Overall, the Health System fills approximately 800,000 prescriptions per year to this group of patients. Medication counseling is available at the time a prescription is filled, but that encounter with a pharmacist or discharge nurse is failing to adequately address the educational needs of the patients relative to their medications, particularly in light of the diversity of culture and language in the patient population. This project dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease medication management among the patients assigned to that clinic.

Medication management is the monitoring of medications a patient takes to confirm that the patient is complying with a medication regimen, while also ensuring the patient is avoiding potentially dangerous drug interactions and other complications. This is especially important for patients taking large numbers of medications to address chronic illnesses and multiple diseases, which is particularly common among older adults, as they are more likely to need medications to manage an array of chronic conditions.

There are a number of aspects to medication management, all of which are focused on making sure that medications are used appropriately. The primary challenge we face in implementing this project include educating providers and patients about the importance of medication management, and assuring providers are aware of and refer patients to the medication counselor role. We expect to address these issues as well as changes to clinical work flow as part of our planning/expansion processes.

The overall goal of conducting pharmacist-led, chronic disease medication management in a defined population is to create a best-practices “model” of processes and information to facilitate appropriate use of medications to control illness and promote health across the Health System’s ambulatory settings. The goal beyond the five years will be to provide the model to conduct medication management so that patients receive the right medications at the right time, across Health System facilities, to reduce medication errors and adverse effects from medication use, and to improve the health of the patient population.

This project addresses Waiver goals of 1) the Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost-effective ways; 2) Improving the health care infrastructure to better serve the Medicaid and uninsured residents of the region; 3) furthering the development of and maintenance of a coordinated care delivery system; and 4) improving outcomes while containing cost growth.
### Starting Point/Baseline:

Currently, no Medicaid or unfunded patients receive the proposed service. The average “hub” clinic, into which smaller clinics feed, has approximately 60,000 visits a year and the average number of prescriptions per unique patient is two. This project will take place in one of the five hub clinics to be determined. Two new pharmacist FTEs will be required. The numerator and denominator for the outcomes measure will be determined in DY2 as the project baseline and processes are defined.

### Rationale:

The project was selected to benefit the majority of the Health System’s patient population who have limited resources and need additional support to understand and manage their medications due to chronic conditions such as diabetes and hypertension. Project option 2.11.2 (Core Component choice c) is addressed in this project as direct contact with a pharmacist in a clinical setting for all patients with multiple medications. Currently, University Health System has a computerized physician’s entry system in place, in which licensed providers can enter orders as appropriate, which facilitates the scope of this project and fulfills core component b. This will benefit those patients who are on multiple medications for the treatment of diabetes, hypertension, congestive heart failure or chronic obstructive pulmonary disease (core component a). Ensuring appropriate use of medication benefits the health care of the patient as well as reducing overall health care costs. A delivery system with a written medication management plan that is consistently followed by all providers can reduce medication errors. Targeted patients who consistently receive medication management are more likely to adhere to their medication regimen and receive the benefits. The plan for the project will be to improve compliance with medication therapy reducing ED visits and admissions and readmissions.

This project addresses CN.1 in general (Texas ranks last in the nation on healthcare quality) and CN.2 in particular (a high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions). The Health System’s experience with the high prevalence of chronic disease and the overwhelming evidence of health care disparities provides the opportunity and the imperative to implement improvements in the management of patients with chronic conditions so prevalent in RHP6.

This project is a new initiative for the Health System. According to the Agency for Healthcare Research and Quality’s 2011 report, Texas ranks last in the nation on health care quality. The report is based on 155 quality measures which include disease prevention efforts, deaths from various conditions, cancer treatment, and how well health care providers manage chronic conditions such as diabetes. Under the category of “Types of Care,” Texas scored “weak” on preventive measures, acute care measures, and chronic care measures. Under the category of “Care by Clinical Area,” Texas scored “weak” on diabetes, heart disease, and respiratory measures, and “average” on cancer measures. The Texas Health and Human Services Commission (HHSC) published various reports related to potentially preventable hospitalizations and readmissions. Between 2005 and 2010, HHSC found that RHP 6 had 125,090 potentially preventable hospitalizations, about 8.5% of the entire state. The conditions studied include bacterial pneumonia, dehydration, urinary tract infection, angina, congestive heart failure, hypertension, asthma, chronic obstructive pulmonary disease, and diabetes. The hospitalizations...
are considered “potentially preventable” because “if the individual had access to and cooperated with appropriate outpatient health care, the hospitalization would likely not have occurred.”

This project will create a pharmacist-led, chronic disease medication management model program for the Health System that will be shared with provider partners in the region. The program will have a direct impact on these quality measures by reducing medication errors and adverse effects from medication use.

**Related Category 3 Outcome Measure(s):**

**OD-2: Potentially Preventable Admissions**

**3-IT-2.11 – Ambulatory Sensitive Conditions Admissions Rate**

a). Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years

Inclusions: Total number of acute care hospitalizations for ambulatory care sensitive conditions* under age 75. This is based on a list of conditions developed by Billings et al., any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions; Chronic obstructive pulmonary diseases; Asthma; Heart Failure and pulmonary edema; Hypertension; Angina; Diabetes

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

Exclusions: Individuals 75 years of age and older; Death before discharge

b) Denominator: Total mid-year population under age 75.

c) Data source: EMR/IDX

d). Reasons/Rationale for selecting the outcome measures: Lack of access to medication or non-compliance with medication instructions are 2 key contributors to increased hospital admissions. Reducing unnecessary admissions benefits the patient and lowers costs for the hospital and the state. A potentially avoidable hospitalization a chronic health condition is commonly associated with a lack of access to appropriate ambulatory care. While not all admissions for chronic conditions are avoidable, it is assumed that appropriate ambulatory care can prevent avoidable admissions through more effective disease management, and control of acute episodes. A high rate of avoidable admissions reflects problems in obtaining access to appropriate primary care.

This pharmacist-led, chronic disease medication management program will have a direct impact on reducing avoidable admissions by reducing medication errors and adverse effects from medication use. Culturally competent pharmacists can effectively remove barriers and communicate with patients to educate them about medications, assure proper usage, answer questions, and provide social and emotional support to patients and their families.

**Relationship to other Projects:**

136141205.1.1 Expand Primary Care Capacity
136141205.1.3 Implement a Chronic Disease Management Registry;
Mental health conditions are prevalent among the population University Health System serves. Providing medication management for patients is critical to avoid complication and avoidable hospitalizations.

**136141205.2.2 Redesign to Improve Patient Experience**

Medication management will provide many patients with information they need in a timely and effective manner. This will improve health outcomes and improve patient satisfaction. Providing the ability to access healthcare in a timely manner and in locations where services are needed will to a better patient experience.

**92414401.2.2 Enhance/Expand Medical Homes –** The PCMH is designed to increase access to primary care through the presence of a medical home model, and access to specialty, preventive services, and medication management offered in one location, in close proximity to patient homes and communities.

**92414401.2.1 Apply evidence-based care management model to patients identified as having high-risk care needs: Implement Care Model for University Health System Clinic settings.**

Medication management is a primary element of a care management model.

**Category 4:**

Related Category 4 measures include potentially preventable admissions measures in RD-1, 30 day readmissions in RD-2, and Patient Satisfaction in RD-4.1 and RD-4.2.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The medication management project has implications and benefits for all Performing Providers in RHP6. Results from this project include a viable model that can be replicated in similar care settings throughout south Texas.

**Plan for Learning Collaborative:**

This project naturally lends itself to participation in a learning collaborative dedicated to care coordination as other Performing Providers seek to develop pharmacist-led, chronic disease medication management programs to reduce avoidable admissions and erase disparities in care. The Health System will actively pursue opportunities to share with interested Performing Providers information and best practices on at least a semi-annual basis.

During model development and implementation of the medication management model we will capture lessons-learned. These will be shared with regional partners who are interested in implementing similar strategies.

**Project Valuation:**

Valuation is based on Achievement of Waiver Goals, Community Needs, Scope of Project, and Project Investment. The addition of a pharmacist to the ambulatory team in a specified Health System “hub clinic” will benefit the community patient, while reducing costs for unnecessary admissions. This program is an essential element in building cost-effective community health care. It strengthens healthcare linkages with local community partners and enhances access to health care services to a target population who struggle with poverty, receive acute or emergency healthcare services only, and do not have usual providers, or access to medication education and
support. In addition, many in the target population have chronic disease and are taking multiple medications. Access to medication counseling will reduce confusion, clarify the best way to manage medications at home and support patients on becoming self-sufficient in caring for themselves and their families.
<table>
<thead>
<tr>
<th>136141205.2.8</th>
<th>2.11.2</th>
<th>2.11.2.c</th>
<th>2.11.2 CONDUCT MEDICATION MANAGEMENT: EVIDENCE-BASED INTERVENTIONS THAT PUT IN PLACE THE TEAMS, TECHNOLOGY AND PROCESSES TO AVOID MEDICATION ERRORS: UNIVERSITY HOSPITAL</th>
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<tbody>
<tr>
<td>PASS 2</td>
<td></td>
<td></td>
<td>University Hospital</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.24</td>
<td>3-IT-2.11</td>
<td>Ambulatory Sensitive Conditions Admissions Rate</td>
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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
<td><strong>Milestone 5</strong></td>
</tr>
<tr>
<td>P-1: Implement/expand a medication management program and/or system</td>
<td>I-9: Manage medications for targeted patients.</td>
<td>I-9: Manage medications for targeted patients.</td>
<td>I-9: Manage medications for targeted patients.</td>
</tr>
<tr>
<td>Metric 1 [P1.1]: Documentation of program, including people, processes and technologies</td>
<td>Metric 1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management</td>
<td>Metric 1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management</td>
<td>Metric 1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management</td>
</tr>
<tr>
<td>Baseline: 0</td>
<td>Numerator: Number of patients that consistently receive medication management counseling at the point of care</td>
<td>Numerator: Number of patients that consistently receive medication management counseling at the point of care</td>
<td>Numerator: Number of patients that consistently receive medication management counseling at the point of care</td>
</tr>
<tr>
<td>Goal: Documentation for plan submitted/Hire one Ambulatory Care Clinical Pharmacist to educate and manage patients with chronic conditions</td>
<td>Denominator: Number of patients in targeted panel size/patient population as defined by the Health System.</td>
<td>Denominator: Number of patients in targeted panel size/patient population as defined by the Health System.</td>
<td>Denominator: Number of patients in targeted panel size/patient population as defined by the Health System.</td>
</tr>
<tr>
<td>Data Source: Draft written medication management plan, including workflow for providers/HR records</td>
<td>Data Source: EMR/IDX</td>
<td>Data Source: EMR/IDX</td>
<td>Data Source: EMR/IDX</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,784,936</td>
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## Milestone 2
**P-4:** Implement an evidence-based program based on best practices for medication reconciliation to improve medication management and continuity between acute and ambulatory setting.

**Metric 1 [P-4.1]:** Written plan to provide medication reconciliation as part of the transition from acute to ambulatory care

- **Baseline:** 0
- **Goal:** Written plan submitted, documenting program policies and procedures that ensures medication reconciliation upon admission and discharge at each care setting for all target population patients.
- **Data Source:** Medication Management Plan

### Milestone 2 Estimated Incentive Payment:
$1,784,936

### Year 2 Estimated Milestone Bundle Amount:
$3,569,872

### Year 3 Estimated Milestone Bundle Amount:
$3,900,510

### Year 4 Estimated Milestone Bundle Amount:
$3,925,727

### Year 5 Estimated Milestone Bundle Amount:
$3,239,053

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $14,635,162
Identifying Project and Provider Information:
Title: 2.12.2 Implement a Care Transitions Project for the CHF Population
Unique RHP ID#: 136141205.2.9 – PASS 3
Performing Provider: University Hospital
Performing Provider TPI: 13614205

Project Summary:
Provider Description: University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty the preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County.

Intervention(s): The project involves the implementation of a care transitions program for patients identified as having congestive heart failure as a primary or secondary diagnosis. A core component of this program is the training of primary care physicians in a patient centered medical home by a culturally competent, board certified cardiology specialist regarding treatment guidelines, algorithms, and other specialty care for CHF patients that can be delivered during routine primary care, which expands the benefit of a patient centered medical home. Within the project the target population and existing pre and post acute services will be identified for more comprehensive engagement, and protocols will be established to prevent hospitalization and/or readmissions.

Need for the project: Data shows approximately 15 trillion USD was spent over a 12-14 year span by CMS for Congestive heart failure and this diagnosis is one of the three most costly readmissions to hospitals across the nation. University Health System cares for approximately 800 patients annually with a primary diagnosis of CHF. Readmission data presented by CMS in 2010 showed a 30.1% readmission rate.

Target population: Patients admitted into University Hospital with primary or secondary diagnoses of congestive heart failure.

Category 1 or 2 expected patient benefits: DY2 and DY3 will be the years for identifying and establishing relationships with pre and post acute services whose interventions are targeted to this population for prevention of hospitalization. Protocols that are evidenced based will be implemented, training of primary care providers by a cardiology specialist will occur and processes will become documented and hardwired across the system.

Category 3 outcomes: IT-3.2 Reduce Congestive Heart Failure 30 day readmission rate by TBD% from baseline by DY5.
**Project Description:**

The project will work towards implementing a care transitions program for patients identified as having congestive heart failure as a primary or secondary diagnosis. The project will primarily help define the target population and the challenges with offering a more comprehensive approach to their specific disease process. The project will identify readmission rates and determine factors for readmission for the CHF population.

The team assigned to facilitate the project will target a patient care unit with a high number of patients admitted with CHF. The pilot program will utilize the tools in Project RED (Re Engineered Discharge) to aid in the reduction of readmission rates and improved clinical outcomes.

The initiative/project includes essential components as follows:

- Review and implementation of best practice models for the population served that addresses readmission rates, reasons and time frames for readmission and post discharge support/calls.
- Assemble, train and work with prioritized post acute providers to improve processes for patients in transition.
- Incrementally implement post discharge planning support based on select interventions from Project RED, the Coleman Model, and Boost based upon lessons learned.
- Regularly identify lessons learned and, utilizing Lean processes, work to eliminate waste and improve transitions of care processes.

The pilot is ambitious and multiple challenges include:

- The availability of ambulatory resources to support the needs of the predetermined population of patients with CHF
- Lack of cultural understanding of the health care needs and expectations of the community
- Lack of infrastructure (staffing) to coordinate the care needed.
- Timely data to address the needs of the patient in order to implement interventions in a timely manner.

The goal of the program will be to reduce readmissions rates for patients diagnosed with congestive heart failure. The benefit for the patient will be improved clinical outcomes due to improved education, better understanding of system utilization, training of health care providers, additional ambulatory support, and post discharge services offered by the Care Coordination department.

The secondary benefit to University Hospital will be future cost avoidance.
Starting Point/Baseline:

Beginning in early 2012, an interdisciplinary committee was established to develop a program using the Project RED guidelines to reduce CHF readmission rates specific to one pilot nursing unit. The team began by identifying the baseline population, establishing the reasons for readmissions and defining the barriers to appropriate post discharge services. Current data from 2011 through the third quarter of 2012 shows 1,205 patients presented to University Hospital with a primary or secondary diagnosis of CHF. Of these patients, 199 returned to the hospital within 30 days. The data was not differentiated by payer, as the project will target Medicare, Medicaid, and the CareLink population. Several tasks accomplished by the group included advancing the education of the nursing staff about CHF education and post discharge education, standardizing national evidence-based CHF education, increasing pharmacy disbursement of 30 day medications, and incorporating downstream providers as part of the committee.

Rationale:

As The Centers for Medicare and Medicaid Services strives to become better stewards of tax payer dollars and simultaneously improve clinical outcomes, a shift in health care has resulted. The responsibility of patient care has begun to transition from being the patient’s responsibility to a partnership between the patient and the health care team. Readmission penalties have placed financial strains on acute providers. Data reflects that approximately 15 trillion USD was spent over a 12-14 year span by CMS for one specific DRG. The data showed that congestive heart failure is one of the three most costly readmissions to hospitals across the nation. University Health System cares for approximately 800 patients annually with a primary diagnosis of CHF; the readmission data presented by CMS in 2010 showed a 30.1% readmission rate. Changes in work patterns in 2012 have shown improvements and decreased the rate for all payers to 14.69%, specifically, 14.5% for Medicare Beneficiaries. Although the data supports improvements in 2012 and the adjustments to clinical practice have shown some benefits, it is difficult to correlate the reduction in readmission rates solely on the clinical practice. “Observation” data for 2012 reflects that an additional 131 patients returned to the hospital for complications related to CHF. Therefore, the data showed a higher than reported readmission rate based on observation visits. The goal of the project will be to reduce the readmission rate by 13% for all payers regardless of geographic location within University Health System.

This project addresses a high prevalence of chronic disease and related health disparities that require greater prevention efforts and improved management of patients with chronic conditions. One of the leading causes of death in RHP 6 includes cardiovascular disease; the pilot will address this population. (CN2)

The project will enhance efforts to date with the Project Red CHF pilot to decrease admissions, decrease readmission, decrease EC utilization, improve patient clinical outcomes, enhance disease specific education, and improve patient satisfaction.
Related Category 3 Outcome Measure(s):

This Outcome Measure was chosen specifically due to supporting facts as follows:
A report written by the CDC on Preventing Chronic Diseases stated, “During 1995-2009, there were 121,741 records with preventable hospitalizations for CHF among adults…this translates to a weighted number of 15,208,518 hospitalization…an average of 1,013,091 readmissions annually” (Will, Valderrama, Yoon, 2012). Based on the State Health Facts, the average cost for admission in the nation is approximately 1798.51/day; this translates to over 27 trillion dollars in 14 years.
The goal will be to reduce CHF readmission rates below the national standard of 24% to 14%.

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

IT-3.2 Congestive Heart Failure 30 day readmission rate (Stand-Alone Measure)

   a) Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
   b) Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal or secondary diagnosis of HF and with a complete claims history for the 12 months prior to admission.

Relationship to other Projects:

The project has multiple implication on other projects within the DSRIP:

A. 2.1 – Enhance/expand the medical home
   a. Care Transitions will support the medical home by coordinating all efforts associated with patient care throughout the care continuum. Care Transitions looks at caring for the patient in an acute setting through the ambulatory resources.
B. 2.3 – Redesign Primary Care
   a. Primary care will be impacted by looking at multiple factors of transitions of care to include education, specialty appointments, referrals, post discharge calls, etc.
C. 2.4 – Redesign to improve patient experience
   a. Improvements in patient experience will be a byproduct of transitions of care. The belief is that once the processes are put in place and the system is improved, patient satisfaction will improve.
D. 2.8 – Apply process improvement methodology to improve quality/efficiency
   a. November 2012, a Lean event is scheduled to assess the level of importance tied to the specific target areas identified within the Transitions of Care Implementation Team.
E. 2.9 – Establish/expand a patient care navigation program
   a. The Care Navigation Program will be impacted by the efforts associated with the transitions of care team.
<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to UHS, Christus Santa Rosa and Guadalupe Regional Medical Center are also addressing the need for transitions of care programs. As projects evolve, there may be the opportunity for sharing best practices, ideas, and solutions across the RHP relative to CHF.</td>
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<tr>
<th>Plan for Learning Collaborative:</th>
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<table>
<thead>
<tr>
<th>Project Valuation:</th>
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<tbody>
<tr>
<td>Project valuation for an efficient and comprehensive Patient Care Transition Program is defined through cost avoidance. Assuming the patients are receiving, case management support, social services support, and medically appropriate patient education, the result should be a reduction of admissions and readmissions as well as a decrease in EC utilization.</td>
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<tr>
<td>136141205.2.9 PASS 3</td>
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<tr>
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</tr>
<tr>
<td>University Hospital</td>
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<tr>
<td>Related Category 3</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
</tr>
<tr>
<td>Milestone 1 [P-X pg. 7]: Establish a baseline, in order to measure improvement over self</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Value: $1,762,829.50</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Value: $2,121,032.50</td>
</tr>
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</table>
community-based organization to create a support network for targeted patients post-discharge.  

**Metric 1 [P-4.1]: Care Transitions assessment**  
- Baseline: 0  
- Goal: Assess internal and external resources for patients diagnosed with congestive heart failure  
- Data Source: Meeting Minutes  

Milestone 2 Estimated Incentive Value: $1,762,829.50  

Milestone 4 Estimated Incentive Value: $2,121,032.50  

| Year 2 Estimated Milestone Bundle Amount: $3,525,659 | Year 3 Estimated Milestone Bundle Amount: $4,242,065 | Year 4 Estimated Milestone Bundle Amount: $4,420,095 | Year 5 Estimated Milestone Bundle Amount: $3,730,722 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,918,541**
### Identifying Project and Provider Information:

| Title: 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with diabetes: University Hospital |
| Unique RHP ID#: 136141205.2.10 (replaces 136141205.2.6) |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

### Project Summary

**Provider Description:** University Hospital (UH) is the 496-bed acute care hospital of University Health System, owned by the people of Bexar County. It serves as the primary teaching hospital for the University of Texas Health Science Center San Antonio, and the lead Level I Trauma Center and safety net provider for the estimated 2 million residents of Bexar County and South Texas. Over the past two decades University Health System has expanded access to primary, specialty and preventive health care services, and currently operates 19 health centers and clinics throughout Bexar County. The Texas Diabetes Institute is University Health System’s specialty clinic which combines 5 centers of excellence for comprehensive diabetes education and care.

**Intervention(s):** Primary care physicians from 4 primary care Community Medicine Associate (CMA) sites at University Health System will receive specialized training under a board-certified endocrinologist for evidence-based, culturally appropriate guidelines for diabetes management and specialty care, including the use of treatment algorithms for low to medium complicated cases, standard guidelines, etc. A diabetes nurse educator from each of these sites will maintain a constant relationship with these patients to act as a resource for education, information, and to ensure adherence to medical advice.

**Need for the project:** About 9.3% (1.7 million) people in Texas have been diagnosed with diabetes. In Bexar County a far greater percent of the population are affected by this disease at 11.8% (137,009). Diabetes is also the 4th leading cause of death in Bexar County. According to statistics from the Behavioral Risk Factor Surveillance system, those at highest risk of developing diabetes are adults, 20 years and older, that make an annual income of less than $50,000 and have an educational attainment of a high school diploma or less. This demographic includes mostly Medicaid and Medicare and uninsured patients. The CMA patient population is comprised of 32.4% CareLink (University Health System’s medical financial aid program), 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay.

**Target population:** The target population includes all patients diagnosed with diabetes, roughly 12,283. The majority of patients diagnosed with diabetes live in the southern and north central areas of San Antonio. This affects the determination of the 4 primary care clinic sites for the project intervention.

**Category 1 or 2 expected patient benefits:** The anticipated 5 year goal is to increase primary care encounters by 20% over baseline (or 30,000 encounters) by enhancing access to managed diabetes health care at the primary care clinic.

**Category 3 outcomes:** IT-1.10 Diabetes care: $HbA1c$ poor control ($>9.0\%$)- *NQF 0059 (Standalone measure)*; IT-1.11 Diabetes care: BP control ($<140/80\text{mm Hg}$), IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)
Project Description:

This project takes a two prong approach using the evidence-based Chronic Care Model at helping patients manage their diabetes through providing training of their primary care providers to stratify the risk of their condition and recommending appropriate treatment, and allowing the patient to receive all necessary care through their usual place of healthcare. The goal of this project is to empower both newly diagnosed and low to medium risk patients and their primary care team to successfully manage their diabetes. By establishing a relationship with their usual primary care team at their usual place of healthcare, patients are more likely to adhere to medical recommendations, which will reduce unnecessary emergency department (ED) visits and improve the overall health indicators and patient outcomes, while lowering the cost of treatment through the prevention of serious complications due to lack of effective diabetes management (Piatt et. al, 2006), (Siminerio, et. al, 2004).

The current multiple challenges include:

- The availability of ambulatory resources to support the needs of the predetermined population of patients with diabetes.
- Lack of cultural understanding of the health care needs and expectations of the community.
- Lack of infrastructure (staffing) to coordinate the care needed.
- Timely data to address the needs of the patient in order to implement interventions in a timely manner.

The proposed program will address these challenges by increasing access to specialty medicine within the confines of the primary care setting, enhancing the relationship between patient and primary care teams, and empowering both to have successful interactions.

The 5 year goal is to expand comprehensive care for diabetes, keeping patients with their primary care team instead of shunting patients to specialty care after diagnosis, as is the current practice. The benefits to the patient including eliminating delays in scheduling appointments, and long wait times, while improving overall access to healthcare, and improvement in the management of diabetes.

The project addresses the following regional goals:

- Triple Aim: assuring patients receive high-quality, patient-centered care, in the most cost effective ways
- Further develop and maintain a coordinated care delivery system
• Improve outcomes while containing cost growth

**Starting Point/Baseline:**
As of September 30, 2011, there are 0 patients served by the project, 0 encounters, and 0 providers trained at these locations for base year.

**Rationale:**
In the United States, safety-net hospital systems remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. In the era of healthcare reform, safety-net hospitals will remain critical to responding to the mandate of providing medical care that is accessible, integrated, and patient-centered. In addition, the evidence makes clear that carefully tailored health services interventions can lead to the establishment of a usual source of care, improve adherence to clinical care and treatment, and strengthen evidence-based clinical preventive service delivery to economically vulnerable, uninsured or underinsured populations. As reported in 2011 by the Agency for Healthcare Research, Texas ranks last in health care quality, specifically scoring “weak” on preventive measures and chronic care measures, including diabetes measures.

In Bexar County 11.8% (137,009) have been diagnosed with diabetes, which is in vast contrast to 9.3% (1.7 million) diabetes in the state. Diabetes is also the 4th leading cause of death in Bexar County. According to statistics from the Behavioral Risk Factor Surveillance system, those at highest risk of developing diabetes are adults, 20 years and older, that make an annual income of less than $50,000 and have an educational attainment of a high school diploma or less. This demographic includes Medicaid and Medicare and uninsured patients. The rate of uninsured in Bexar County is 23% further highlighting the need for increased access. The CMA patient population is comprised of 32.4% CareLink (University Health System’s medical financial aid program), 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay.

To combat these disparities and increase healthcare access, University Health System; the major safety-net hospital for South Central Texas proposes to follow the Chronic Care Model, and expand the role of primary care providers at four patient-centered medical home sites. This is considered an integrated model of health service delivery that focuses on providing high quality, affordable, accessible, and culturally appropriate health care alongside a clinical practice that is efficient, evidence-based and utilizes inter-operable information systems to address primary, urgent and specialty care needs.

The project components are to:

a) Design and implement care teams that are tailored to the patient’s health care needs, which will occur through training by a board-certified, culturally competent endocrinologist regarding diabetes treatment and management, which include recommended guidelines for diabetes management, treatment algorithm, etc, and through the establishment of a relationship with a diabetes nurse educator so that diabetes management and overall health care can remain accessible to the newly diagnosed or moderate to low risk patient.
b) Ensure that patients can access their regular primary care teams, specifically the diabetes nurse educator, in person or by phone in the location of their usual care.

c) Increase patient engagement, by having the diabetes nurse educator provide the patient with educational material regarding diet, lifestyle, adherence to medication and coordination with community resources to help the patient maintain control over their overall healthcare and diabetes.

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

e) Conduct quality improvement by having the health teams meet bi-weekly to report and present any barriers, issues and lessons learned to the program manager, and other providers.

These program components reflect the project option’s core components, a through e.

This project addresses CN.2, improved management of patients with chronic conditions. Specifically, the local identified need of increased access to chronic health management.

Implementation of this program will ensure patients have access to improved management of their chronic conditions in an environment that they are familiar with, and with providers they are comfortable with. This is a change in the flow of usual care. Currently all diagnosed patients are referred by their primary care physician to receive specialty care at the Texas Diabetes Institute. Patients can be lost to care and result in low or no control of their diabetes, and other chronic illnesses because of barriers such as transportation to a more distant clinic, long wait times for an appointment, etc. Poor control over their diabetes results in unnecessary complications and visits to the ED.

Measures of performance will include both process and outcomes measures that assess progress towards implementation milestones. These include: 1) expanding the chronic care model to primary care sites, 2) integration and access (expanded services that address target population needs), and 3) quality of care and cost-effectiveness. In summary, establishing an expansion of the role of primary care providers responds to national health aims of delivering high quality care, improving population health and reducing healthcare costs.

**Related Category 3 Outcome Measure(s):**

In 2010, the Texas Chronic Disease Burden Report through the Texas Department of State Health Services established that the prevalence of diabetes in Texas surpasses that of the nation, and accounts for $1,075,284,123 per year in total hospital charges, in which 53.4% of the primary source of payment came from Medicaid or Medicare. Coupled with low scores for national health quality standards for chronic care, such as diabetes care, and the prevalence of poor control of diabetes management, University Health System proposes to adopt the Chronic Care Model in the primary care setting to empower the primary care and patient team to successfully manage the patient’s chronic conditions, thus improving the patient’s overall outcomes (Siminerio, Zgibor, Solano, 2004), (Stellefson, Dipnarine, Stopka, 2013). Focusing on Category 3 outcomes related to primary care and chronic disease management, such as the levels of HbA1c, blood pressure, and LDL, and short term complication admission rates will show the level of success that patients had with the program model. By improving diabetes management, long term complications can be avoided and overall reductions in costs from prevention of complications, as has been demonstrated throughout the literature.
Relationship to other Projects:
By utilizing the Chronic Care Model in the primary care setting, there is an opportunity to complement other projects within the RHP plan or to have other projects complement the goals and objectives of this project.

136141205.1.3- Implement and use chronic disease management registry functionalities
136141205.1.2- Expand existing primary care capacity: University Hospital expanding capacity
092414401.2.1- Apply evidence-based care management model to patients identified as having high-risk care needs: Implement Care Model for Clinic settings

Relationship to Other Performing Providers’ Projects in the RHP:
N/A

Plan for Learning Collaborative:
N/A

Project Valuation:
In Bexar County 11.8% (137,009) have been diagnosed with diabetes, which is in vast contrast to 9.3% (1.7 million) diabetes in the state. Diabetes is also the 4th leading cause of death in Bexar County. In face of such high prevalence of diabetes in Bexar County, effective management is necessary to reduce the burden of the disease and the cost of treatment of complications. Texas has failed to meet the national standards for health care quality measures regarding diabetes. This innovative, evidence-based approach will increase help meet the three part CMS aim of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways, which translates to reducing the costs due to unnecessary hospitalizations and the treatment of complications related to poor control of diabetes.
Each project site has been chosen because of the proximity to areas where the majority of UHS’ diabetic population resides.
<table>
<thead>
<tr>
<th>136141205.2.10</th>
<th>2.2.1</th>
<th>A-E</th>
<th>2.2.1 Redesign the outpatient delivery system to coordinate care for patients with diabetes: University Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces 16141205.2.6</td>
<td></td>
<td></td>
<td>University Hospital</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>136141205.3.30</td>
<td>3.IT-1.10</td>
<td>Diabetes care: HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td></td>
<td>136141205.3.31</td>
<td>3.IT-1.11</td>
<td>Diabetes care: BP control (&lt;140/80mm Hg)</td>
</tr>
<tr>
<td></td>
<td>136141205.3.32</td>
<td>3.IT-1.6</td>
<td>Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 1</td>
<td>Milestone 3</td>
<td>Milestone 6</td>
<td>Milestone 8</td>
</tr>
<tr>
<td>P-2: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care</td>
<td>P-2: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care</td>
<td>I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option.</td>
<td>I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option.</td>
</tr>
<tr>
<td>Metric [P-2.1]: Increase percent of staff trained</td>
<td>Metric [P-2.1]: Increase percent of staff trained</td>
<td>Metric [I-21.4]: Improved compliance with recommended care regimens.</td>
<td>Metric [I-21.4]: Improved compliance with recommended care regimens.</td>
</tr>
<tr>
<td>Goal: Have 4 primary care physicians trained at 1 site by September 30, 2013.</td>
<td>Goal: Have 4 primary care physicians trained at 2 additional sites by September 30, 2014.</td>
<td>Goal: To have 80% of patients seen at project sites in compliance with care regimen.</td>
<td>Goal: To have 80% of patients seen at project sites in compliance with care regimen.</td>
</tr>
<tr>
<td>Data Source: HR, training program materials</td>
<td>Data Source: HR, training program materials</td>
<td>Data Source: EMR</td>
<td>Data Source: EMR</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,469,947.50</td>
<td>Milestone 3 Estimated Incentive Payment: $1,070,728.33</td>
<td>Milestone 6 Estimated Incentive Payment: $1,616,475.50</td>
<td>Milestone 8 Estimated Incentive Payment: $1,333,728</td>
</tr>
<tr>
<td>Milestone 2</td>
<td>Milestone 7</td>
<td>Milestone 9</td>
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<tr>
<td>P-12: Participate in at least</td>
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<td>Milestone 4</td>
<td>Milestone 5</td>
<td>Milestone 6</td>
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<tr>
<td><strong>Milestone 4</strong>&lt;br&gt;P-1: Expand the Chronic Care Model to primary care clinics&lt;br&gt;Metric [P-1.1]: Increase number of primary care clinics using the Chronic Care model&lt;br&gt;Goal: Have 1 clinic sites using the Chronic Care model in primary care by September 29, 2013.&lt;br&gt;Source: Documentation of practice document&lt;br&gt;Milestone 2 Estimated Incentive Payment: $1,469,947.50</td>
<td><strong>Milestone 5</strong>&lt;br&gt;P-12: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come.&lt;br&gt;P-12.1. Metric: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.&lt;br&gt;Baseline: 0&lt;br&gt;Goal: Meet bi-weekly to discuss any lessons learned, issues, etc.&lt;br&gt;Source: Meeting Agenda/Notes&lt;br&gt;Milestone 9 Estimated Incentive Payment: $1,333,728</td>
<td><strong>Milestone 6</strong>&lt;br&gt;P-1: Expand the Chronic Care Model to primary care clinics&lt;br&gt;Metric [P-1.1]: Increase number of primary care clinics using the Chronic Care model&lt;br&gt;Goal: Have 3 additional clinic sites using the Chronic Care model in primary care by September 29, 2014.&lt;br&gt;Source: Documentation of practice document&lt;br&gt;Milestone 4 Estimated Incentive Payment: $1,070,728.33&lt;br&gt;Milestone 7 Estimated Incentive Payment: $1,616,475.50</td>
<td></td>
</tr>
</tbody>
</table>
provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come.

P-12.1. Metric: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.

Baseline: 0
Goal: Meet bi-weekly to discuss any lessons learned, issues, etc.
Source: Meeting Agenda/Notes

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Milestone Bundle Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>$2,939,895</td>
</tr>
<tr>
<td>Year 3</td>
<td>$3,212,185</td>
</tr>
<tr>
<td>Year 4</td>
<td>$3,232,951</td>
</tr>
<tr>
<td>Year 5</td>
<td>$2,667,456</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $12,052,487**
Identifying Project and Provider Information:
Title: 2.10.1 – Implement a Palliative Care Program to address patients with end of life decisions and care needs
Unique RHP ID#: 121782003.2.1 – PASS 2
Provider Name: Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital (UMH)
TPI: 121782003

Project Summary:
Provider Description: Uvalde Memorial Hospital is a 66-bed sole community hospital located in Uvalde, TX serving approximately 47,000 individuals residing within 5 counties (7,000 square mile area).

Intervention(s): The project will offer palliative care services for patients and their families. It will emphasize the importance of comfort and quality of life for high risk patients who have late stage chronic illnesses.

Need for the project: A high percentage of palliative care appropriate patients are being transferred home without hospice or home health care services. Currently none of the neighboring hospitals in nearby counties offer palliative care services.

Target population: The target population is our high risk patients with late stage chronic illnesses. Our hospital operates with a Medicaid inpatient utilization rate higher than 50% and a low income utilization rate also higher than 50%. 32% percent of the population within our service region is uninsured.

Category 1 or 2 expected patient benefits: The project will increase the number of palliative care discharges to hospice from the DY 3 baseline by 60 patients in DY 4 and 120 patients in DY 5. These numbers are based on approximately 2,000 total hospital discharges in 2012. It is has been estimated that new palliative care programs can expect to see 1% of total discharges and well established programs can expect to see 10% of total discharges. We have set ambitious goals of 3% of discharges by DY 4 and 6% by DY 5. A goal of a 20% improvement over DY 3 baseline scores on the patient/family experience survey for palliative care services has been set for DY 5.

Category 3 outcomes: IT-13.4 Our goal is to reduce the percentage of patients admitted to the ICU in the last 30 days of life. Percent reduction goals TBD in DY 3.

Project Description:
Uvalde Memorial Hospital seeks to implement a palliative care program to address patients with end of life decisions and care needs
Currently, many hospice appropriate patients are being transferred home without care. This causes many of these patients to frequent the ICU in their last 30 days of life. This is costly for the patient’s family and is often not the most comfortable, pain free way to spend the last days of life. UMH will implement a new palliative care program in DY 3 while achieving milestones in DY 2 to DY 5. First, UMH will develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. Then we will develop an EHR/system (e.g. a rounding tool or a registry or software) that analyzes the palliative care system data to determine if the program is effective. These two steps will lay the groundwork for implementing the program.
Once the program is implemented, a record will be kept of the conditions for which palliative care is consulted (COPD, CHF, cancer, etc.). One of the goals of the program is to increase the number of palliative care discharges to home care, hospice, or a skilled nursing facility while minimizing transfers to ICUs, hospital stays and home discharges without services. UMH will set the goal of 60 new palliative care discharges from the DY 3 baseline in DY 4 and 120 new palliative care discharges in DY 5. Another goal will be to increase the number of patients who are not only screened for pain during their hospice admission evaluation and/or palliative care initial encounter but who also receive a comprehensive clinical assessment for pain within 24 hours of screening positive for pain. Patients and their families will be surveyed to measure satisfaction with the new palliative care program.

Goals and Relationship to Regional Goals:
Patients will receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. This service will also greatly reduce return emergency room visits while also reducing hospital inpatient days for hospice appropriate patients.

Project Goals:
- Increase discharges to hospice and SNF while decreasing discharges home without services
- Substantially decrease the rate of potentially preventable re-admissions
- Decrease the proportion admitted to the ICU in the last 30 days of life (Cat. 3: IT-13.4)

This project meets the following regional goals:
- Work together to make significant progress towards the Triple Aim goals of assuring patients receive high-quality and patient-centered care, in the most effective ways.
  - Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our region.
  - Further develop and maintain a coordinated care delivery system.
  - Improve outcomes while containing cost growth.

The project achieves an improved infrastructure for Medicaid and uninsured residents through ensuring quality care for hospice or SNF care for appropriate patients who are uninsured. The project develops and maintains a coordinated care delivery system through communicating with and educating patients, families, physicians and care givers. The project improves outcomes while containing cost growth by reducing PPRs and ICU admits in the last 30 days of life.

Challenges:
When starting any new program such as this there are always challenges, particularly with ensuring medical staff support. One of the key pieces to this program is presenting a solid business case to the medical staff for their review. Providing adequate palliative care training to ancillaries, physicians and primary care specialties will also build support for the program. This is vital to ensuring that hospice or SNF appropriate patients are given a palliative care consult and transferred into the care of one of these two services in our community.

5-Year Expected Outcome for Provider and Patients:
This service will greatly reduce return emergency room visits while also reducing hospital inpatient days for hospice appropriate patients. The patient will receive hospice care from highly trained specialists in palliative care. The patient will experience much better quality of life and...
their family will receive support as well while reducing the cost care and the burden on UMH.

**Starting Point/Baseline:**
The baselines for improvement milestones, [I-9] and [I-11], will be established in DY 3. This baseline is currently 0 or in other words, cannot be established until DY 3 because the palliative care program won’t be fully implemented until this year. Process milestones associated with this project have 0 baselines, again because this program represents an new service to our community.

**Rationale:**
This project also meets the regional goals and community needs of RHP 6 and fills a pressing need in our community. This project option was selected because it meets the Triple Aim goals of the waiver
- high-quality care
- patient-centered care
- most effective care

Specific project components that will address these goals and community needs are outlined below.

a. *Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program* – UMH will include this component into this palliative care project by achieving [P-1]. This component is essential to the project as it will garner support from the medical staff, primary care specialties and ancillary staff.

b. *Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility* – This component is the main focus of the project. It will be addressed by the achievement of improvement milestone [I-9]. This improvement milestone will increase palliative care discharges to home care and/or hospice and/or SNF by 60 patients in DY 4 and 120 patients in DY 5. Patient transfers will depend on what makes the most sense given each patient’s condition during the palliative care consult.

c. *Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time* – This component will be addressed by the project through the achievement of improvement milestone [I-12]. The goal for this project is to improve scores by 10% in DY 4 and 20% in DY 5.

d. *Conduct quality improvement for project using methods such as rapid cycle improvement* This component will be addressed by the project through the achievement of improvement milestones [I-12] and [I-11]. The patient/family satisfaction survey results will give UMH valuable insight to what areas of the program require greater attention and quality improvement resources. The achievement of [I-11] targets (40% DY 4 patients, 60% of DY 5) will improve the quality of palliative patient care while also identifying areas within pain management that will be improved upon throughout the project.

**Unique community need identification numbers the project addresses:**
- CN.1 – Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.2 – A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patient with chronic conditions. Leading causes of death in RHP 6 include cardiovascular disease, cancer and diabetes.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
There is not currently a palliative care program in our service region or in any of the neighboring hospitals’ service region. This program would complement UMH’s pass 1 project, 121782003.1.1. Community health workers and an expanded primary care capacity will ensure regular follow up and will further promote the palliative care consults. The greatly improved communication channels between physicians, care givers and patients/families from this pass 1 project will facilitate the palliative care program.
*This initiative, and any related activities, is not being funded in whole or part by the U.S. Department of Health and Human Services.*

**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>OD-13: Palliative Care</th>
<th>IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life (stand-alone measure)</td>
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</table>

**Reasons/rationale for selecting the outcome measures:**
These outcome domains with their associated improvement targets were chosen after considering the outcomes most likely to be impacted the most by the project. These outcomes are also a priority for RHP 6 because they directly related to CN.1, and CN.2 in the RHP community needs assessment. Specifically, achieving improvement milestone [I-9] percentage improvements in discharges to hospice, SNF and other care will contribute towards the achievement of IT-13.4.

**Relationship to other Projects:**
The primary way this project supports, reinforces, enables and is related to other projects and interventions within the RHP plan are through contribution to RHP 6 goals. However, the RHP 6 anchor facility, University Hospital, is also implementing a palliative care program. We plan on being involved in learning collaboratives with University Hospital to facilitate discussion and improvement in palliative care services offered to our community.

**Related Category 4 Population-focused measures.**

<table>
<thead>
<tr>
<th>RD-2: 30-day readmissions</th>
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<tbody>
<tr>
<td>RD 4: Patient-centered Healthcare</td>
</tr>
</tbody>
</table>

**Relationship to Other Performing Providers’ Projects in the RHP:**
University Hospital, PA: 2.10

**Plan for Learning Collaborative:**
UMH plans to participate in an RHP-wide learning collaborative with other providers with similar projects. “RHP 6 is committed to transforming health care in our region and throughout the state. Given the large number and value of projects proposed for our region, University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives.”
Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
- Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

UMH plans to be a significant part of learning collaboratives with other performing providers with similar projects.

<table>
<thead>
<tr>
<th>Project Valuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This project scored high in all categories used to assess project value to the RHP and to our community. Categories included in the valuation process included: project scope, achieves waiver goals, and addresses community needs and project investment. Uvalde Memorial Hospital also values each project based on the following factors: the potential impact on health of our population, the resources necessary to implement the project, and level of improvement anticipated in overall patient satisfaction. UMH also took into account the extent to which reducing 30 day PPRs, increasing transfers to hospice care for appropriate patients, and reducing the number of inpatient days will have on cost. Most importantly, this project was valued based on its potential impact on regional and Waiver goals.</td>
</tr>
<tr>
<td>121782003.2.1 PASS 2</td>
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<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>[P-1]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program</td>
<td>Milestone 2</td>
<td>[P-3]: Implement palliative care education and training programs for providers (RNs, PAs, NPs, etc.) that incorporate management of non-cancer patients.</td>
<td>Milestone 4</td>
</tr>
<tr>
<td>Metric 1 [P-1.1]: Business case Baseline: 0, no palliative care business case or program currently exists at UMH or at any of the neighboring rural hospitals. Goal: Submission of business case Data Source: Business case write-up; documentation of planning activities</td>
<td>Metric 2 [P-3.1]: Palliative care training and education for other providers Baseline: 0, There are not currently any palliative care education programs at UMH for providers Goal: Documentation of training provided and education curriculum Data Source: Database that tracks type and number of training and education sessions by health professional category</td>
<td>Metric 3 [I-9.1]: Transitions accomplished. Numerator: Number of palliative care discharges to home care, hospice, or SNF. Denominator: Total number of palliative care discharges Baseline: Number of palliative care discharges in DY 3 Goal: 60 additional palliative care discharges to home care and/or hospice and/or SNF by the end of DY 4. Patient transfers would depend on what makes the most sense given</td>
<td>Metric 4 [I-9.1]: Transitions accomplished. Numerator: Number of palliative care discharges to home care, hospice, or SNF. Denominator: Total number of palliative care discharges Baseline: Number of palliative care discharges in DY 3 Goal: 120 additional palliative care discharges to home care and/or hospice and/or SNF by the end of DY 5. Patient transfers would depend on what makes the most sense given</td>
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<td>Milestone 5</td>
<td><strong>Milestone 6</strong></td>
<td><strong>Milestone 7</strong></td>
<td><strong>Milestone 8</strong></td>
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<td>Milestone 6</td>
<td>Milestone 7</td>
<td>Milestone 8</td>
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<tr>
<td>Milestone 2</td>
<td>(physicians, RNs, Pas, NPs, etc.)</td>
<td>Goal: Charter for Palliative care program; Operational plan; palliative care team and hiring agreements; Data Source: Palliative care program records</td>
<td>Milestone 2 Estimated Incentive Payment: $ 270,946</td>
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<tr>
<td>[P-2]: Educate primary care specialties in providing palliative care including non-cancer training.</td>
<td>Milestone 3 Estimated Incentive Payment: $ 197,360.5</td>
<td>Data Source: EHR, database</td>
<td>Milestone 3 Estimated Incentive Payment: $ 197,360.5</td>
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<tr>
<td>Metric 1 [P-2.1]: Primary care specialties training and education in palliative care Baseline: 0, There are not currently any palliative care education programs at UMH for primary care specialties Goal: Documentation of training provided and education curriculum. Data Source: Database that tracks type and number of training and education sessions by health professional category (family medicine, internal medicine, pediatrics, geriatrics, and other IM subspecialties)</td>
<td>Milestone 4 Estimated Incentive Payment: $ 197,360.5</td>
<td>Milestone 6 Estimated Incentive Payment $ 198,636.5</td>
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<tr>
<td>Milestone 4</td>
<td>Milestone 7</td>
<td>Milestone 5</td>
<td>Milestone 10</td>
</tr>
<tr>
<td>[P-5]: Implement a palliative care program</td>
<td>[I-11]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care</td>
<td>[P-8]: Document the conditions for which palliative care is</td>
<td>[I-11]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care</td>
</tr>
<tr>
<td>Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 0, There is not currently a palliative care program at UMH or at any of the neighboring rural hospitals. Goal: Charter for Palliative care program; Operational plan; palliative care team and hiring agreements; Data Source: Palliative care program records</td>
<td>Milestone 4 Estimated Incentive Payment: $ 197,360.5</td>
<td>Milestone 6 Estimated Incentive Payment $ 198,636.5</td>
<td>Milestone 9 Estimated Incentive Payment $ 163,891.5</td>
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<tr>
<td>Milestone 5 Estimated Incentive Payment: $ 197,360.5</td>
<td>Milestone 7 Estimated Incentive Payment $ 198,636.5</td>
<td>Milestone 8 Estimated Incentive Payment $ 197,360.5</td>
<td>Milestone 10 Estimated Incentive Payment $ 163,891.5</td>
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<tr>
<td>Milestone 9</td>
<td>Milestone 10</td>
<td>Milestone 10 Estimated Incentive Payment $ 163,891.5</td>
<td>Milestone 10 Estimated Incentive Payment $ 163,891.5</td>
</tr>
<tr>
<td>[I-11]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care</td>
<td>Metric 1 [I-11.2] Pain assessment (NQF-1637) – Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Numerator: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain Denominator: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on</td>
<td>Metric 1 [I-11.2] Pain assessment (NQF-1637) – Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Numerator: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain Denominator: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on</td>
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<td>Metric [P-8.1]: Breadth of conditions for which palliative care is utilized. Numerator: Number of chronic conditions for which the palliative care patients are consulted. Denominator: Total number of patients admitted with chronic conditions or MCC. Baseline: 0, There is not currently a palliative care program at UMH or at any of the neighboring rural hospitals. <strong>Goal:</strong> Documentation of palliative care consults conducted in DY 3 across a breadth of conditions, including non-cancer patients (e.g. COPD exacerbation, heart failure exacerbation, fluid overload in an ESRD patient, etc.). Data Source: EHR, palliative care database. Milestone 5 Estimated Incentive Payment: $197,360.5</td>
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<td>the admission evaluation/initial encounter. Baseline: Number of patients in DY 3 who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. <strong>Goal:</strong> 40% of DY 4 patients enrolled in hospice OR receiving palliative care, who report pain when pain screening is done on the admission evaluation/initial encounter, receive a comprehensive clinical assessment to determine the severity, etiology and impact of their pain, within 24 hours of screening. Data Source: EMR, palliative care database. Milestone 7 Estimated Incentive Payment: $198,636.5</td>
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<td>Milestone 10 Estimated Incentive Payment: $163,891.5</td>
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<td><strong>Milestone 8</strong> [I-12] Implement a patient/family experience survey regarding the quality of care, pain and symptom. <strong>Goal:</strong> 60% of DY 5 patients enrolled in hospice OR receiving palliative care, who report pain when pain screening is done on the admission evaluation/initial encounter, receive a comprehensive clinical assessment to determine the severity, etiology and impact of their pain, within 24 hours of screening. Data Source: EMR, palliative care database. Milestone 11 Estimated Incentive Payment: $163,891.5</td>
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<tr>
<td>Milestone 11 [I-12] Implement a patient/family experience survey regarding the quality of care, pain and symptom. <strong>Goal:</strong> 60% of DY 5 patients enrolled in hospice OR receiving palliative care, who report pain when pain screening is done on the admission evaluation/initial encounter, receive a comprehensive clinical assessment to determine the severity, etiology and impact of their pain, within 24 hours of screening. Data Source: EMR, palliative care database. Milestone 11 Estimated Incentive Payment: $163,891.5</td>
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management, and degree of patient/family centeredness in care and improve scores over time

Metric1: Survey developed and implemented; scores increase over time
Baseline: DY 3 data from patient/family surveys

Goal: 10% improvement over DY 3 patient satisfaction scores for palliative care or ≥90% patient satisfaction.
Data Source: patient satisfaction surveys

Milestone 8 Estimated Incentive Payment $198,636.5

| Year 2 Estimated Milestone Bundle Amount: $541,892 | Year 3 Estimated Milestone Bundle Amount: $592,082 | Year 4 Estimated Milestone Bundle Amount: $595,910 | Year 5 Estimated Milestone Bundle Amount: $491,675 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,221,558
## Identifying Project and Provider Information:

| Title: 2.2.2 Apply evidence-based care management model to patients identified as having high-risk care needs: Implement Care Model for Clinic settings |
| Unique RHP ID#: 092414401.2.1 – PASS 2 |
| Performing Provider: Community Medicine Associates |
| Performing Provider TPI: 092414401 |

## Project Summary:

| Provider Description: Community Medicine Associates (CMA) is the primary care practice of University Health System, a publicly supported, academic medical center and safety net provider. CMA serves the San Antonio area with an estimated population of 1.7 million. CMA currently has approximately 100 providers who practice within an ambulatory network of 19-primary, specialty and preventive health clinics located throughout Bexar County. |
| Intervention(s): This project will establish an interdisciplinary care coordination team within its ambulatory network of care. These teams will be comprised of RN case managers, social workers, and patient educators to identify and support chronic and other health care needs and education of patients the receive services at respective regional medical home clinics. This interdisciplinary model of care will also be tailored to addressing the health needs and preferences of the patient population including appropriately accessing use of community and organizational resources, enhancing the patient’s knowledge of the disease process(es), and facilitate healthy decisions to reduce risk for chronic disease and or disease self-management. |
| Need for the project: The Community Needs Assessment reported that approximately 470,000 residents in RHP 6 remain uninsured (C.N.3) and the foundation for their care is dependent on the services offered by University Health System. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes (C.N. 2). This project was selected because the incorporation and partnership of RN’s, Social workers, and patient educators (Care Management model) all working at the top of their skill sets can better assist provider shortages (C.N.3) will not only improve patient outcomes, provider and patient satisfaction, but reduce hospital admissions, EC visits. |
| Target population: The target population will include the CMA patient population, specifically those patients dealing with 2 or more chronic conditions (50%). CMA is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay. |
| Category 1 or 2 expected patient benefits: This project will establish and expand a comprehensive care management program in primary care clinics in DY 2, DY 3 and DY4. This will result in improvements in clinical outcomes and reduced utilization for patients served under the care management model and 50 percent of eligible patients will have a documented self-management goal in the EMR by DY5. Patient benefits from established care coordinated processes and procedures will include enhanced quality of care and patient experience. |
| Category 3 outcomes: 3.1T-2.13 Other Admissions Rate |

- **DY4** – Decrease admission rate by TBD% for patients enrolled in care management program.
- **DY5** – Decrease admission rate by TBD% for patients enrolled in care management program.

**Project Description:**

Community Medicine Associates has identified the need to establish and align an interdisciplinary care coordination team including, but not limited to RN Case Managers, Social Workers, and Patient Educators to identify and support chronic and other health care needs and education. This model will educate the patient on the appropriate use of community and organizational resources, increase the patient’s knowledge of the disease process(es), and facilitate healthy decisions.

Project goals are: improved clinical outcomes, decreased hospital admission/readmissions, decreased EC utilization and increased patient and provider satisfaction. The anticipated 5 years goal is 50% of patients have a documented self management goal in the EMR.

The Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases, offering “lessons learned” to our partners in RHP6 through the appropriate Learning Collaborative to be established.

The project is ambitious and requires significant coordination at several levels within the organization. Current challenges:
- University Health System is a large system where coordination of services and patient education are prioritized due to current-state deficiencies, fragmentation, and silos
- The infrastructure and tools necessary to better coordinate the care needs and education of patient-specific populations need to be developed
- Finding the patient story in the EMR is very difficult
- Provider turnover has been high
- Access is not timely
- Patient engagement processes are limited
- There is significant variation in policies and procedures and workflow processes relative to Access and care coordination in the Ambulatory setting
- Existing care coordination roles have different reporting relationships, and
- Available data is often historical rather than timely
- Provider turnover has been significant

By addressing these needs within the RHP Plan, University Health System is placing more emphasis on a much needed model of improved communication and care coordination in the Ambulatory arena that addresses patient level interactions and education, individually and in aggregate.

**Relationship to Regional Goals**

This project will further achievement of the regional goals of the Triple Aim; improved health care infrastructure to better serve Medicaid and currently uninsured residents in RHP 6; reduce
health disparities; further develop and maintain a coordinated care delivery system; and improve outcomes while containing cost growth. The health system will monitor, evaluate and adjust the project based on quality improvement activities throughout the development and implementation phases.

**5 Year Expected Outcome for Provider and Patients:**
University Health System expects to see improvements in clinical outcomes and in reduced utilization of the ER for patients served under this care management model. The anticipated 5 years goal is that fifty percent of patients will have a documented self management goal in the EMR.

**Starting Point/Baseline:**
Prior to July of 2012, no patients within University Health System’s Ambulatory clinics were being served under a Care Management Model. In early 2012, a Director to implement and oversee a care management model was put in place. In mid 2012, University Health System hired, oriented and began piloting two Case Managers in two ambulatory clinics. Early active caseloads are approximately 42 patients per case manager. Four Social workers were pre-existing and support all of Ambulatory with a different reporting relationship. Patient educators are dispersed throughout the Ambulatory clinics. Discussions are just beginning to assess better alignment and the working relationships of case managers, social workers, and patient educator roles per setting. Encounter data is just occurring along with accompanying software capability. The organization has prioritized Exitcare as the predominant source of patient education materials and is in the early stages of organizational implementation.

**Rationale:**
The Community Needs Assessment reported that approximately 470,000 residents in RHP 6 remain uninsured (C.N.3) and the foundation for their care is dependent on the services offered by University Health System. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes (C.N. 2).

This project was selected because the incorporation and partnership of RN’s, Social workers, and patient educators (Care Management model) all working at the top of their skill sets can better assist provider shortages (C.N.3) will not only improve patient outcomes, provider and patient satisfaction, but reduce hospital admissions, EC visits.

Unique community need identification numbers the project addresses:
CN.2 - Address the high prevalence of chronic disease and related health disparities in the community through greater prevention efforts that focus on addressing chronic disease.

CN.3 – Address the lack of medical and dental health services in the community due to high rates of uninsured and provider shortages.

This project will “significantly enhance” the current state by enlarging and establishing standardized processes for patient engagement and patient care management as needed for the population served. This project addresses a high prevalence of chronic disease and related health
disparities that require greater prevention efforts and improved management of patients with chronic conditions. Ultimately, 6 of the 15 sites will have an established Care Management Program, serving 600 patients in DY3 and 900 in DY4.

**Related Category 3 Outcome Measure(s):**

- OD-2 Potentially Preventable Admissions
- IT-2.13 Other Admission Rate (Stand-alone measure)
  - f. Numerator: Admissions to hospital
  - g. Denominator: Active panel of patients for Care Team
  - h. Data Source: EMR/IDX/Crimson/Truven Health/Allscripts

The purpose of selecting the outcome measure in category three is to measure the impact of a care management model on preventing admissions. Evidence has been evolving subsequent to recent demonstration projects that improved patient engagement and management in the community directly impacts reduced hospitalizations, mortality, and quality of life.

**Relationship to other Projects:**

- 092414401.1.1 Expand training of the primary care workforce
  Training future providers in primary will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

- 092414401.2.2 Enhance/Expand Medical Homes – The PCMH is designed to increase access to primary care through the presence of a medical home model, and access to specialty and preventive services offered in one location, in close proximity to patient homes and communities.

Category 4 measures include emergency department in RD-5 and patient-centered healthcare, including patient satisfaction and medication management in RD-4

**Relationship to Other Performing Providers’ Projects in the RHP:**

- The project has multiple implications on other projects within our RHP.
  - 136141205.1.4 – Introduce, expand, or enhance telemedicine/telehealth
    o The Care Model will involve coordinating care, educating the patient, and addressing clinical needs via multiple modes of communication to include telephonic conversations and potentially secure web based face to face conversations.
  - 92414401.2.2 – Enhance/expand the medical homes
    o The Care Model will expand the medical home concept by offering services that would otherwise be unavailable. These services include, but are not limited to, case management, social services, and patient education.
  - 136141205.2.2 – Redesign to improve patient experience
    o Research has proven that patient satisfaction will increase as a result of the implementation of a Care Management Model. The expectation will also be to
improve provider satisfaction within our ambulatory clinics. A recent study completed with the Affinity Health System showed an increase in provider satisfaction and patient compliance.

- 136141205.2.4 – Establish/expand a patient care navigation program
  - Care Management Model is a method of navigating the patient throughout the health care continuum while simultaneously addressing chronic conditions identified by the patient’s provider.

There are a total of 3 organizations within RHP 6 who will address 2.2 Expand Chronic Care Management Models. As the focus of this project is predominantly the adult population, there may be opportunity to share best practices and lessons learned with UTHSCSA as these projects evolve.

**Plan for Learning Collaborative:**

University Health System is very interested in sharing best practices, lessons learned, and other ideas to improve chronic care management models. We will participate in face-to-face meetings and/or conference calls to regularly share data related to the efficacy of various practices along with lessons learned as we implement this program.

**Project Valuation:**

Project valuation for an efficient and comprehensive Care Model was rated at the highest valuation level and is defined predominantly through cost avoidance. Assuming the patients are receiving, case management support, social services support, and medically appropriate patient education, the result should be a reduction of admissions and readmissions as well as a decrease in EC utilization. Patient and provider satisfaction will be improved with projected valuation, as well. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
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<thead>
<tr>
<th><strong>092414401.2.1</strong></th>
<th><strong>2.2.2</strong></th>
<th><strong>N/A</strong></th>
<th><strong>2.2.2 Apply evidence-based care management model to patients identified as having high-risk care needs: Implement Care Model for Clinic settings</strong></th>
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<tbody>
<tr>
<td><strong>PASS 2</strong></td>
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<td><strong>Community Medicine Associates</strong></td>
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<tr>
<td><strong>TPI - 092414401</strong></td>
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<td><strong>Other Admission Rate (Stand-Alone Measure)</strong></td>
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<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>092414401.3.2</strong></td>
<td><strong>3.IT- 2.13</strong></td>
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<td><strong>Year 2</strong></td>
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<td><strong>Milestone 1</strong></td>
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<tr>
<td><strong>P-3: Develop a comprehensive care management program</strong></td>
<td><strong>P-1: Expand the Care Model to primary care clinics.</strong></td>
<td><strong>P-3: Develop a comprehensive care management program</strong></td>
<td><strong>P-10: Expand and document interaction types between patient and health care team beyond one-to-one visits to</strong></td>
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<td><strong>Metric 1 [P-3.1]: Documentation of Care Management Program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care’s Assessment Model may be utilized in program development.</strong></td>
<td><strong>Metric 1 [P-1.1] Increase number of primary care clinics using Care Model</strong></td>
<td><strong>Metric1 [P-3.2]: Increase the number of patients enrolled in a Care Management Program over baseline</strong></td>
<td><strong>Milestone 7</strong></td>
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<td><strong>Baseline: No current program Goal: Establish and document a comprehensive Care Management Program Data Source: Program Materials</strong></td>
<td><strong>Baseline: 3 of the 15 sites, or 20% of the clinics have an established Care Management Program Goal: Expand to 3 more clinic sites, or 6 of the 15 (40%) of the sites will have an established Care Management Program Data Source: HR/ Care Coordination Department</strong></td>
<td><strong>Baseline: DY3 Goal: Target 150 patients in the Care Management Program at each clinic site (900 total). Data Source: Allscripts; IDX; Other</strong></td>
<td><strong>Milestone 7</strong></td>
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<td><strong>Milestone 1 Estimated Incentive Payment: $712,402</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment: $1,116,494.50</strong></td>
<td><strong>Milestone 6 Estimated Incentive Payment: $754,691</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment: $2,313,374</strong></td>
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<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 8</strong></td>
<td><strong>Milestone 9</strong></td>
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<td><strong>P-10: Expand and document interaction types between patient and health care team beyond one-to-one visits to</strong></td>
<td><strong>P-5: Implement Care Management Program in Clinic settings</strong></td>
<td><strong>P-8: Establish and document comprehensive Care Management Program</strong></td>
<td><strong>I-18: Improve the percentage of patients with self-management goals</strong></td>
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<td><strong>Metric 1 [I-18.1]: Patients with self-management goals.</strong></td>
<td><strong>Metric1 [P-5.1] Increase the number of patients managed using Care Model</strong></td>
<td><strong>Baseline: 0 Goal: Establish self-management goals for patients managed within the Care Model. Target is 50% of patients enrolled in Care management program will have documented self management goals. Data: Allscripts; IDX, other</strong></td>
<td><strong>Baseline: 0 Goal: Establish self-management goals for patients managed within the Care Model. Target is 50% of patients enrolled in Care management program will have documented self management goals. Data: Allscripts; IDX, other</strong></td>
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<td><strong>Milestone 2 Estimated Incentive Payment: $1,116,494.50</strong></td>
<td><strong>Milestone 5 Estimated Incentive Payment: $2,313,374</strong></td>
<td><strong>Milestone 8 Estimated Incentive Payment: $2,313,374</strong></td>
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| **P-1**: Expand the Care Model to primary care clinics.  
**Metric 1 [P-1.1]** Increase number of primary care clinics using Care Model  
Baseline: 0 of 15 sites currently have a Care Management Program with aligned staff to influence chronic disease states  
Goal: 3 of the 15 or 20% will have a Care Management Program established  
Data Source: HR, Care Coordination Department  
Milestone 2 Estimated Incentive Payment: $712,402 | **P-3**: Develop a comprehensive care management program  
**Metric 1 [P-3.1]** Increase the number of primary care clinics using Care Management Program over baseline  
Baseline: 0  
Goal: Target 100 patients actively engaged in the Care Management Program at each clinic site (600 total).  
Data Source: Allscripts; IDX, other  
Milestone 5 Estimated Incentive Payment: $1,116,494.50 | **P-8** [P-X] Quality Metric pg. 7: Assess efficacy of processes in place and recommend process improvements to implement, if any.  
**Metric 1 [P-X]** Quality Metric pg. 7: Perform at least two PDSA workshops to determine the success of the program, document whether the anticipated metric include group visits, telephone visits, and other interaction types.  
**Metric 1 [P-10.1]** Increase the number of group visits and/or telephone visits and/or other interaction types.  
Model  
Baseline: 0  
Goal: Conduct 2 group visits per quarter with a minimum of 15 patients per session.  
Data Source: Allscripts  
Milestone 7 Estimated Incentive Payment: $754,691 |
| Goal: 100% of staff hired into model in year 2 | improvements were met, and modify the program if necessary. Baseline: 0 Goal: Conduct and document 1 quarterly PDSA workshop. Address all Care Management Program site locations and review population for admissions/readmissions. Data Source: Meeting minutes | Milestone 3 Estimated Incentive Payment: $712,402 |
| Milestone 8 Estimated Incentive Payment: $754,691 |
| Year 2 Estimated Milestone Bundle Amount: $2,137,206 | Year 3 Estimated Milestone Bundle Amount: $2,232,989 | Year 4 Estimated Milestone Bundle Amount: $2,264,073 | Year 5 Estimated Milestone Bundle Amount: $2,313,374 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,947,642** |
Identifying Project and Provider Information:
Title: 2.1.1 - Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: Community Medicine Associates
Unique RHP ID#: 092414401.2.2 – PASS 2
Performing Provider: Community Medicine Associates
Performing Provider TPI: 092414401

Project Summary:
Provider: Community Medicine Associates (CMA) is the primary care practice of University Health System, a publicly supported, academic medical center and safety net provider. CMA serves the San Antonio area with an estimated population of 1.7 million. CMA currently has approximately 100 providers who practice within an ambulatory network of 19-primary, specialty and preventive health clinics located throughout Bexar County.

Intervention(s): This project will achieve Level 3 Patient Centered Medical Home (PCMH) recognition in order to provide improved quality, better access and more efficiency.

Need for the project: Many patients, specifically CareLink patients, are in need of chronic disease management, care coordination, and timely access to medical and social services. The PCMH will be built around this CareLink population and has been shown to improve chronic disease management, improve quality of care, and decrease costs associated with avoidable hospitalizations or emergency center visits (NCQA Patient-Centered Medical Home website). A major component of the PCMH model is patient self-management where patients take initiative to partner with providers to proactively manage their health.

Target population: This is a portion of the CareLink (Bexar County Indigent) patient population. In 2011, CareLink members averaged 4 primary care visits per year. 32% of CareLink members were seen at least once for hypertension, 22% were seen at least once for diabetes, and 18% were seen at least once for hyperlipidemia (high cholesterol). There were 580,234 prescriptions filled last year for CareLink members.

Category 1 or 2 expected patient benefits: This project will expand and re-organize primary care staff to more fully integrate elements of the PCMH. The Health System will continue to implement and integrate core elements of the PCMH between DY3 and DY5 resulting in an 8% increase in patient encounters over baseline year and NCQA/PCMH recognition by DY5. Expected benefits to the patient population include improved quality and increased access to primary care within a medical home setting.

Category 3 outcomes: 3.IT-9.2 ED Appropriate Utilization
- **DY4** – Decrease ED visits by TBD% for patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma from baseline.
- **DY5** – Decrease ED visits by TBD% for patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma from baseline.
Project Description:

Many patients at University Health System are not identified with one provider or care team. They may be seen by different personnel at every visit and therefore their health and health care are not well coordinated. This can result in frequent avoidable hospital stays and ED visits. The target population will include the CMA patient population which is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. Due to high utilization of healthcare resources and an overall need for better health coordination, CareLink members would benefit from a Patient Centered Medical Home (PCMH) program.

In 2011, CareLink members averaged 4 primary care visits per year. 32% of CareLink members were seen at least once for hypertension, 22% were seen at least once for diabetes, and 18% were seen at least once for hyperlipidemia (high cholesterol). There were 580,234 prescriptions filled last year for CareLink members. The challenge will be to coordinate care for this large population while increasing quality and managing cost. There are so many touch-points where patients can access care, providing consistent, quality, coordinated care will challenging to implement and manage. A major component of the PCMH model is patient self-management where patients take initiative to partner with providers to proactively manage their health. Clinics will need to educate patients on value of self-management and encourage them to feel in control.

University Health System goals include: Preparation of a gap analysis to determine NCQA Patient Centered Medical Home readiness. Develop training and education for key stakeholders to the importance of NCQA certification and impact on quality of patient care. Develop plans and processes to connect patients to a medical home. Provide new patients assigned to a primary care medical home an appointment to be seen within 60 days of referral. By developing systems to identify and prioritize patients in need of medical home assignment, defining appropriate provider panel sizes, and criteria for prioritizing patients for medical homes, University Health System aims to have 50% of clinics using the medical home model by DY 5.

The 5-year expected outcome would be to improve access utilizing innovative methods like group and telephone visits and appropriately assigning patients to their medical home in order to impact costly visits to emergency rooms and potentially avoidable admissions.

This achieves the following regional goals:
- Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Further develop and maintain a coordinated care delivery system
**Starting Point/Baseline:**

CareLink as well as established patients assigned to University Health System medical home will serve as our selected patient population. Our starting point will be to pilot a primary care medical home model at one of the major primary care clinics. New patients assigned to medical homes will receive their first appointment in a timely manner. Care teams will actively manage their patient panel so that patients are reminded of services needed and receive coordinated care based in a primary care setting. Patients will know the professionals on their care team and establish trusting, ongoing relationships to reinforce continuity of care.

For the baseline year of October 1st, 2011 through September 30th, 2012, there were 244,382 CMA primary care encounters.

Primary care encounters include: CMA primary care network (all locations that provide primary and preventive services)

**Rationale:**

In the United States, safety-net hospital systems remain essential to providing access to health services for over 50 million uninsured Americans as well as other underserved populations. In the era of healthcare reform, safety-net hospitals will remain critical to responding to the mandate of providing medical care that is accessible, integrated, and patient-centered. In Bexar County, Texas, 22% of residents live at or below the poverty level, 17% receive no medical care due to cost, and 21% have no form of health insurance coverage.

In addition, assessments of health behaviors in this area reveals that 49% of adults are physically inactive, 30% are either overweight or obese, 77% consume less than five servings of fruit or vegetables per day, and 33% have had one or more days where their mental health was poor.

This project specifically addresses community need two (CN.2) which finds a high prevalence of chronic disease and related health disparities in the region which require greater prevention efforts and improved management of patients with chronic conditions. RHP 6 has a high rate of mortality associated with chronic conditions including cardiovascular disease, cancer, and diabetes.

Evidence from demonstration PCMHs shows that carefully tailored health services interventions can lead to the establishment of a usual source of care, improved adherence to clinical care and treatment, and strengthen evidence-based clinical preventive service delivery to economically vulnerable, uninsured or underinsured populations.

The purpose of this program is to expand established patient assignment into medical homes to engage patients in a care setting where a continuous care plan can be put in place and to ensure that they have access to services that are targeted to their personal health needs. This will subsequently improve geographical coverage and access to clinical and community preventive services through expansion of the patient-centered medical home. This accountable model of care will focus on common aims, priorities, and goals to ensure that all patients receive the right care including recommended clinical preventive services, at the right time, in the right setting, every time. Since CareLink members are unfunded, and have high prevalence of chronic disease,
unmanaged healthcare will cost billions. Implementing the PCMH provides patients with access to care to control chronic conditions, reduce costly inpatients or ED visits, and ultimately improve patient health and satisfaction. Expanding the PCMH and the delivery clinical preventive care within University Health System ambulatory facilities will improve health, health care and reduce costs. The milestones selected for this program (e.g. P-3, P-9,P-10, I-13, I-18, and I-19) are centered on developing care teams aimed at clinical integration and access, thereby improving overall healthcare, reducing wait times and unnecessary hospitalizations, and improving patient satisfaction.

University Health System operates University Hospital, a 496 bed full service facility, including trauma and emergency services for the region, 19 health centers and clinics providing primary care and specialty care, as well as acute care and preventive services. University Health System will coordinate care between our facilities to establish patient centered services. The system will expand our primary care base, incorporate clinics using the medical home concept, and train staff on PCMH methodologies. This will open new channels of access for our community to comprehensive, managed healthcare. Implementation of this model ensures patients have access to a seamless system of care that focuses on reduced wait times, timely scheduling of appointments, advanced communication and e-messaging with health care teams, data systems to support population health, case management, care coordination, support for patient self-care and development of performance reporting and improvement plans to measure the medical and financial impact of care delivered.

Measures of performance as outlined include both process and outcomes measures that assess progress made towards implementation milestones including measures of clinical expansion (establishment of patient-centered medical home site) integration and access (expanded services that address target population needs), quality and cost-effectiveness. In summary, establishing this clinical preventive model of care strengthens the organizational mission and responds to national health aims of delivering high quality care, improving population health and reducing healthcare costs.

This project addresses the following core components:

a) Utilize a gap analysis to assess and measure NCQA PCMH readiness: University Health System anticipates utilizing the NCQA PCMH criteria for accreditation to develop the PCMH at University Health System and measure readiness through the development process.
b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status: University Health System will determine PCMH readiness and necessary steps during baseline assessment phase. Reorganization of staff into primary care teams (Milestone 1) is expected to occur during this time.
c) Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision: University Health System anticipates the development of an online PCMH training program, and will train PCMH personnel on concepts (Milestone 5).
d) Conduct quality improvement for project using methods such as rapid cycle improvement: The University Health System will monitor, evaluate, and adjust the project based on quality improvement activities throughout the development and implementation phases. Because the PCMH is being piloted at a small number of sites
 Initially, a key focus will be on identifying “lessons learned” opportunities to scale the PCMH model to more sites and a broader patient population.

**Related Category 3 Outcome Measure(s):**

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The target population will include the CMA patient population which is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

**IT-9.2 ED appropriate utilization (Standalone measure)**

- Reduce all ED visits (including ACSC)271
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

**Relationship to other Projects:**

092414401.1.1 (Pass 2 CMA): Expand training of the primary care workforce – Implementation of the PCMH will require all medical providers to be trained in updated clinical workflows. Also, the PCMH increases the need for mid-level providers, patient navigators and care coordinators. Training future providers in primary care will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

092414401.2.1 (Pass 2 CMA): – Expand Chronic Care Management Models – implementing PCMH concepts in the ambulatory setting will be a more coordinated approach of managing a patient’s overall health. Many CareLink patients have chronic conditions that will benefit from this new connection with their provider(s).

**Category 4:**

Related Category 4 measures include potentially preventable admissions measures in RD-1, 30 day readmissions in RD-2, Patient Satisfaction in RD-4.1 and RD-4.2.
### Relationship to Other Performing Providers’ Projects in the RHP:

**Category 1:**
- 136141205.1.1: Expand Primary Care Capacity – higher enrollment in the medical home model will place a higher priority on maintaining a relationship with a primary care providers through other avenues than just clinic visits
- 92414401.1.1: Expand training of the primary care workforce – Implementation of the PCMH will require all medical providers to be trained in updated clinical workflows. Also, the PCMH increases the need for mid-level providers, patient navigators and care coordinators. Training future providers in primary care will assist with filling the need to create more access for patients and having newly trained providers to staff additional clinical sites

**Category 2:**
- 92414401.2.1: Expand Chronic Care Management Models – implementing PCMH concepts in the ambulatory setting will be a more coordinated approach of managing a patient’s overall health. Many CareLink patients have chronic conditions that will benefit from this new connection with their provider(s).
- 136141205.2.2: Redesign to Improve Patient Experience
  Providing the ability to access healthcare in a timely manner and in locations where services are needed will lead to better patient experience. This can also be replicated with local and regional partners.
- 136141205.2.3: Apply process improvement methodology to improve quality and efficiencies: LEAN methodologies will be used to develop and implement improved clinical workflows, provider tools and training for staff in process improvement, and efficient, quality care delivery to the community.

### Plan for Learning Collaborative:

This project lends itself to participation in learning collaboratives as other Performing Providers in RHP6 seek to develop patient-centered primary care services in other parts of the region for similar patient populations. Processes and techniques developed and implemented during this project will be documented by the project team. Successes as well as lessons learned will be shared with regional collaborators who are also working to improve primary care access and quality.

### Project Valuation:

The project achieves the waiver goal and meets community needs by expanding primary care in a predominantly Hispanic, underserved area of Bexar County. This program strengthens healthcare linkages with local community partners, enhances access to primary care and assures improved quality care services to a target population that struggles with poverty, receive acute or emergency healthcare services only, and do not have usual providers. In addition, many in the target population have chronic disease; with no primary care access these condition will become far more complicated and costly to treat. Access to a primary care medical home been has shown to improve health, improve health care, and lower care costs.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>092414401.3.3 3.IT-9.2</th>
<th>ED Appropriate Utilization (Standalone measure)</th>
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<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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**Milestone 1**

P-3 Reorganize staff into primary care teams responsible for the coordination of patient care

**Metric 1: P-3.1 Primary care team**

Baseline: 0

Goal: Have all primary care staff assigned into a team from 1 primary care site.

Data Source: Documentation of staff assignments into care teams. Meetings, training, documents in minutes

Milestone 1 Estimated Incentive Payment: $1,068,603

**Milestone 2**

I-19 Develop or expand principles of medical home and patient centered care using innovative project option

**Milestone 3**

P-9 Train medical home personnel on PCMH change concepts

**Metric 3: P-9.1 Number of medical home personnel % trained out of potential that are eligible to participate.**

Goal: 60% of eligible medical home personnel will be trained out of potential that are eligible to participate.

Data Source: Training records and HR documents

Milestone 3 Estimated Incentive Payment: $744,329.67

**Milestone 4**

I-19 Develop or expand principles of medical home and patient centered care using innovative project option

**Metric 4: I-19.2 Increase number of patient centered visits**

Goal: Increase primary care encounters 6% over baseline year (259,045 anticipated encounters)

Data Source: Registry, EHR, claims or other PP sources

Milestone 4 Estimated Incentive Payment: $1,132,036.50

**Milestone 5**

Milestone 5: Track the assignment of patients to the

**Milestone 6**

I-19 Develop or expand principles of medical home and patient centered care using innovative project option

**Metric 6: I-19.2 Increase number of patient centered visits**

Goal: Increase primary care encounters 8% over baseline year (263,933 anticipated encounters)

Data Source: Registry, EHR, claims or other PP sources

Milestone 6 Estimated Incentive Payment: $771,124.67

**Milestone 7**

I-18 Obtain medical home recognition by a nationally recognized agency

**Milestone 8**

Milestone 8 Estimated Incentive Payment: $771,124.67

**Milestone 9**

Milestone 9 Estimated Incentive Payment: $771,124.67

Milestone 9: Track the assignment of patients to the
Metric 2: I-19.2 Increase number of patient centered visits
Baseline: 244,382 primary care encounters in DY1.
Goal: Increase primary care encounters 2% over baseline year (249,270 anticipated encounters)
Data Source: Registry, EHR, claims or other PP sources

Milestone 2 Estimated Incentive Payment: $1,068,603

Metric 4: I-19.2 Increase number of patient centered visits
Goal: Increase primary care encounters 4% over baseline year (254,157 anticipated encounters)
Data Source: Registry, EHR, claims or other PP sources

Milestone 4 Estimated Incentive Payment: $744,329.67

Milestone 5
I-18 Obtain medical home recognition by a nationally recognized agency
Metric 5: I-18.1 Medical home recognition/accreditation
Goal: 1 out of 4 primary care clinics
Data Source: Documentation of recognition/accreditation from nationally recognized agency

Milestone 5 Estimated Incentive Payment: $744,329.67

Metric 7: P-7.1. Metric: Tracking medical home patients
Goal: Develop baseline data of patients making appointments with their designated care team.
Data Source: Practice management system, EHR, and other documentation.

Milestone 7 Estimated Incentive Payment: $1,132,036.50

Metric 9: I-18.1 Medical home recognition/accreditation
Goal: 2 out of 4 primary care clinics
Data Source: Documentation of recognition/accreditation from nationally recognized agency

Milestone 9 Estimated Incentive Payment: $771,124.67

Milestone 10
P-7. Milestone: Track the assignment of patients to the designated care team
Metric 10: P-7.1. Metric: Tracking medical home patients
Goal: Improve percent of appointments made with designated care team by 5%
Data Source: Practice management system, EHR, and other documentation.

Milestone 10 Estimated Incentive Payment: $771,124.67
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<th>Year 2 Estimated Milestone Bundle Amount: $2,137,206</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,232,989</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,264,073</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,313,374</th>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $8,947,642</td>
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Identifying Project and Provider Information:

Title: 2.7.6 Implement innovative evidence based strategies to significantly reduce and prevent lead poisoning and asthma in children and adolescents by targeting environmental aspects of children’s health (TEACH). Unique Project ID: 085144601.2.1 – PASS 1
Performing Provider: The University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Project Summary:

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Division of Community Pediatrics (CP) is a division within the Department of Pediatrics. The CP division has over 25 professionals, organized into multi-disciplinary teams engaged in the provision of health care, translational health care research into the areas of respiratory and pulmonary health, research for children and families living with HIV/AIDS, early child growth and development, adolescents and adolescent pregnancy. The Department of Family Medicine provides medical care for children, adolescent and adults. Family Medicine conducts national and regional experiments regarding the building of medical homes.

Intervention(s): Integrate and coordinate health and behavioral health intervention/prevention as well as lung functioning tests to assess the severity of asthma and monitor the course of project interventions. Neuropsychological assessment and interventions, for lead and asthma exposed children will be accessed to evaluate physical, neuropsychological and parental health management services. This project will implement lead and asthma prevention and intervention services for children and families living in housing identified by City and HUD officials as having environmental contamination for lead or other respiratory hazards. Approximately 1488 children and families will receive treatment for lead poison and/or asthma.

Need for the project: Bexar County has the 3rd highest incidence rate for Elevated Blood Lead Levels (EBLLs) in Texas and among the worst 10% of U.S. cities for lead exposure risk (Environmental Defense Fund, 2011). Asthma, the most frequent chronic childhood illness affecting 12% of school-age children causes 23% of elementary school absences in Bexar County. In 2011, children in Bexar County (19,980) were screened for childhood lead, and 1000 qualified for chelation therapy. Of the 630,935 San Antonio children under age 18, 45,427 have been diagnosed with asthma. Asthma, the most frequent chronic childhood illness affecting 12% of school-age children causes 23% of elementary school absences in Bexar County (2011 Bexar County Community Health Assessment).

Target population: The San Antonio Empowerment Zone/Enterprise Community (EZ/EC) target area represents the highest lead exposure incidence rates, highest rates of abandoned housing, poverty, single mothers, teen births, and Sexually Transmitted Diseases (STD’s) within Bexar County. The EZ/EC target area has 59,732 low-income housing and 46% were built prior to 1978 and 12.8% were built prior to 1940. Approximately 22% of San Antonio’s children under the age of six live within EZ/EC area and 70% of the 3-5 years of age Head Start children in the area (5447) in the area are Medicaid recipients. Sixty-Five percent (65%) of all house members in the EZ/EC area live below the federally defined poverty level. Childhood blood lead level screening in 2012 identified 236 children with blood lead exposed and 120 (50.8%) had elevated blood lead levels (≥10 µg/dL). Children residing in the EZ/EC zone were
over represented for asthma hospitalizations with 17.76% of all asthma in San Antonio. In 2011 the City of San Antonio received Federal funds the U.S. Department of Housing and Urban Development program to support San Antonio’s Green and Healthy Homes Initiative (S.A.-GHHI) to implement lead, asthma and mold hazard remediation, asbestos removal, water conservation, fire prevention, integrated pest management and safety mitigation. This proposed 1115 grant initiative incorporates strong partnerships with the S.A. GHHI Collaborative Board which is composed of San Antonio’s Green and Healthy Homes (S.A. GHHI) (formerly the Lead-Based Paint Hazard Control Program), San Antonio Metropolitan Health District (SAMHD), San Antonio Fire Department, Code Enforcement Services, San Antonio Water System, Office of Environmental Policy, City Public Service, Family Service Association (a faith-based, 501(c)(3)), the University of Texas Health Science Center San Antonio Division of Community Pediatrics and the Department of Family Medicine. Community Pediatrics will provide leading screening and medical referral to a primary health provider. Community Pediatrics will provide lead and asthma education and medical consultation for children with asthma/lead for Medicaid enrolled children. Approximately 1488 Medicaid and indigent children manifesting lead/asthma symptoms, and who reside in substandard housing will receive project services. Project participants will receive medical and wrap-around psychosocial interventions by Community Pediatrics and Family Medicine staff. Community collaboration for project sustainability will be done with the City of San Antonio Planning and Community Development Department and S.A. GHHI partners.

Category 1 or 2 expected patient benefits: This project will use an empirically designed evidence based program (Krieger J. et al. “A Randomized Controlled Trial of Asthma Self-Management Support Comparing Clinic-based Nurses and In-home Community Health Workers,” Archives of Pediatric and Adolescent Medicine. 2009;163(2):141-149. Note: statistically significant differences in health outcomes were observed for only symptom-free days in the last 2 weeks and caregiver quality of life score.)

Category 3 outcomes: Reduction/prevention in Emergency room admission and sick days of Medicaid children with asthma/ elevated lead levels will be accomplished by: (a) primary medical intervention and preventive services to remediate environmental health problems by project staff. Collaborative neuropsychological assessments and environmental and psychosocial interventions will help address the medical and psychosocial needs of children and establish and sustain a City-wide program for respiratory and lead exposed children. This an evidenced based project, and is a multi-agency and county-wide, medical, bio-psychosocial initiative.

Project Description:

Purpose of the Project: Implement an innovative evidenced-based disease prevention program
for children diagnosed with lead poisoning and asthma, and children with asthma to Reduce Emergency room admissions. **Project Goal:** (1). Reduce the severity of childhood asthma and childhood lead symptoms that contributes to E.R visits, (2) Decrease preventable asthma morbidity, (3) Decrease the number of emergency room visits, school absents due to sick days, and decrease number of in home sick days, (4) Improved quality of life for lead/asthma children and parents.

- **Reduce the severity of asthma symptoms by 20%:** GGHI Collaborative Board of City of San Antonio Officials, Metropolitan Health District, Housing Authority, University Hospital and UTHSCSA Community Pediatrics and UTHSCSA Family Medicine will oversee and assure successful integration of (a) weatherization and, energy efficiency interventions for property remediation (b) environmental strategies to control asthma, allergens (mold, insects, dust mites, pet dander etc) and environmental irritants (tobacco smoke, indoor/outdoor fumes, sprays/scents, (c) Primary health lead /asthma education, health knowledge assessment, lead/asthma prevention and intervention instructions and medical referrals, (d) recommendations from home environmental assessment provide by professional environmental consultants will provide home energy assessment, health and safety checks and Indoor air quality testing to determine level of volatile organic compounds, allergens, mold, and formaldehyde with the participants home.

- **Improve Quality of Life of participants with lead/asthma by 20%:** Quality of life changes, improved patient access to coordinate health and behavioral health care, and health literacy will be accessed by standardized parent and child health quality of life surveys, psychological tests and pulmonary lung functioning tests results, especially from the asthma participants. Community Pediatrics will provide six in home education sessions to individuals with lead, lead and asthma or asthma only. Quarterly lead asthma education sessions will be offered to healthcare providers, school educators and other environmental health officials. Advanced statistical methods to access the rapid cycle of improvement between health literacy, health intervention and health prevention will be used.

- **Decrease the number of lead and or Asthma Morbidity/Severity by 15%:** UTHSCSA Community Pediatrics and Family Medicine in conjunction with Metropolitan Health District health staff will create a process for triage, referral, remediation, health education prevention and intervention to reduce the morbidity/severity of asthma /lead symptoms as assessed by (1) number of school absent,(2) number of parent reported sick days, and (3) number of routine hospital visits (4) episodic emergency room visits and (5) number of visits to a primary healthcare provider or school nurse. Unit cost of analysis of base line morbidity/severity variables in comparison to post intervention cost analysis will be conducted and a 15% morbidity/ severity reduction is expected.

**Background:** Asthma is the fourth most common reason for pediatrician office visits. Asthma affects over 1 million Texas children. The rates of asthma vary widely geographically in the county, with lower rates of diagnosis in low SES regions of the county. The Assessment notes that the Bexar County Physical Environment, including housing, can affect chronic conditions like asthma. Texas Hispanic children are more likely to be hospitalized due to asthma than non-Hispanic white children. Exposures that cause airway inflammation and trigger asthma include:
indoor irritants and allergens such as tobacco smoke, cockroaches, animal dander, dust mites, mold, and volatile organic chemicals (VOCs). Frequently, these exposures are associated with older housing stock where lead exposure may also be a concern. Children with blood lead levels of $\geq 0.5 \mu g/dL$ may suffer disproportionally from respiratory and immunological impairments as well as neurocognitive, developmental and mental health deficits later in life. Medicaid and uninsured children have less access to primary health preventive services due to low Medicaid reimbursement rates for asthma that fail to promote environmental interventions that have the potential to address the underlying causes of asthma. Most reimbursement goes toward medications, hospitalization, ER visits, with few, if any, resources directed toward reducing or eliminating contributory environmental exposures.

**Methodology:** How The Project Will Be Addressed: The Departments of Pediatrics and Family and Community Medicine will partner to coordinate comprehensive lead and asthma integrated “Primary and Behavioral health interventions and Prevention Services.” Medicaid-enrolled children presenting with lead exposure and or asthma will be enrolled in the proposed 1115 waiver project. Community Collaborative partners will include the San Antonio local Housing and Urban Development Green and Healthy Homes Division and the San Antonio Metropolitan District (SAMHD), who will make referrals of San Antonio children with documented elevated blood lead levels via blood screening and asthma for the duration of the project. The target population will consist of 1488 client’s residing in San Antonio’s public housing units. Based current S.A. Housing Authority housing census data and on previous HUD funded lead and asthma projects (2002-2005 and 2007-2009) conducted in San Antonio, we expect each home to consist of 4 individuals, with at least one child between the ages of 2 and 9 years, 11 months, and 29 days with diagnosed elevated blood lead levels and/or asthma. The overall population impact therefore would allow this study to reach approximately 1,488 individuals. Baseline respiratory health will be determined by caregiver report on a respiratory health-screening instrument.

**Family and Community Medicine (FCM) Scope of Work: Asthma Environmental Assessments and Recommendations for reducing E.R. visits and in-home sick days:**

**(A) Background, Medical, and Environmental Information:** FCM will work with Pediatrics to obtain basic medical information relevant to environmental medical exposures for each child including personal exposure history, total IgE, RAST tests for common allergens, blood lead levels, cotinine test, and pulmonary function test results.

**(B) Environmental House Calls (EHC):** FCM will implement a series of environmental house calls in each child’s home to evaluate salient residential exposures. These inspection tools, along with the EPA Asthma Home Environment Checklist, will guide the home evaluations. A series of three house call visits per family is necessary. A minimum of two community health professionals with prior training in environmental house calls will conduct each home visit. During the first visit the family will receive basic information about asthma and accompany the EHC team on a walkthrough visit to identify potential concerns. Two weeks later, at the second visit, family will receive an action plan and discuss recommended interventions environmental, housing remediation’s and personal changes i.e. smoking, pet’s and dust control.. The final house call will occur approximately 6 months later, to assess changes that were made in the home and changes in the child’s asthma control.

**(C) Assessment of EHC Intervention:** Each child’s medical history will be reviewed for the
following: hospital and ER records, doctor visits, medication requirements, days lost from school and family assessment (TRACK survey).

(D) Proposed Environmental House Call Intervention for Asthma: FCM will develop an intervention plan that marries environmental and medical concerns and interventions in a manner designed to complement and enhance the HUD-funded lead/asthma initiative.

- Homes evaluated for safety and environmental risk factors for children.
- Baseline environmental testing including CO/CO2, particulates, volatile organic compounds indoor and outdoor mold samples, and humidity will be assessed in each housing unit.
- Individual action plan developed to include: Interventions include education regarding integrated pest management (IPM), source control (such as removing candles; improving storage and use of cleaners), mold and relevant education on other allergens (cockroach, pet dander, and dust mite).
- Environmental assessment will be done during the 3rd (final) visit in an effort to assess the reduction of known asthma triggers made in the unit since the initial visit.

(E) Research Team: The team will consist of experienced FCM faculty and staff from the South Texas Environmental Education and Research (STEER) program who have conducted environmental house calls and asthma trainings for more than 15 years throughout South Texas (San Antonio, Laredo, Harlingen). FCM will provide training to FCM staff (community health workers) from San Antonio on the identification and management of indoor air asthma triggers.

Pediatrics Scope of Work—Medical Intervention and Prevention: Medical Evaluation:
The Pediatric Department will be responsible for the medical evaluation of children with environmentally induced illnesses, including asthma and lead toxicity. Pediatrics will recruit Medicaid enrolled children with asthma. Pediatrics will perform an initial medical evaluation and medical tests that may be necessary to guide environmental inspections of each child’s home (e.g., RAST testing for relevant allergens, cotinine levels). Pediatrics will then communicate these results to the EHC team. Once a home assessment has been completed, FCM/EHC will communicate concerns to the Pediatric team. Intervention and prevention components conducted by Pediatrics will include:

The Baseline Intake Information: The caregiver will complete a survey battery that includes: (1) demographics, (2) Brief Symptom Inventory (BSI: Derogatis), (3) Crisis in Family Systems (4) a biomarker survey (5) Time of any lead exposure (prenatal, postnatal); (6) Prenatal history (maternal alcohol use, maternal smoking, maternal drug use, infant birth weight); (7) Family history (respiratory problems, diabetes); (8) Environmental exposures (pesticide use, environmental tobacco smoke, dust, rodents, mold, etc.); and (9) Other (hygiene, nutrition, educational stimulation, presence of developmental delays, & cultural influences).

Pediatric Pulmonology: Will perform a blood draw on the child to obtain: 1) the serum levels total IgE, 2) total eosinophils, 3) Radio Allergo Sorbent Test (RAST) for household allergens, 4) cortisol level, and 5) lead level. Respiratory health-related information will be provided to the caregiver and this information will be extended to the PCP. The caregiver will provide the venous lead test results and TRACK standardized asthma symptom survey results to their Primary Care Physician PCP for further follow-up. Parent Education: 1) Basic facts about
asthma, 2) Role of medications, 3) Techniques in using an inhaler/spacer/holder chamber and how to self-monitor for asthma symptoms and 4) Environmental control measures, and 5) When and how to take rescue actions. The education sessions will use knowledge of home conditions reported by the EHC team to customize the educational intervention to better meet the family’s needs. **Educational Curriculum:** In home Seven (7) session curriculum, this includes the receipt of non-toxic cleaning supplies (e.g., vinegar, baking soda). Service and Linkages: Pediatrics will provide information and referrals to community services and organizations that can assist with food, medical care, and other necessities. For instance, staff will refer participants to Medicaid or the Children’s Health Insurance Plan (CHIP) as needed. **Child Psychosocial and Neuropsychological Assessment:** One of the following three developmental/cognitive assessments will be administered to each child based on age and language: Mullen Scale of Early Learning (Mullen, 1995) (<5 years); the Wechsler Preschool and Primary Scales of Intelligence-III (WPPSI-III; Psych. Corporation, 1993) (≥5 years; English speakers); the Wechsler Nonverbal Scales of Ability (WNV; Wechsler & Naglieri, 2006) (≥5 years; Spanish speakers). Caregivers will complete the Digit Span, Digit Coding, and Picture Completion subtests (Spanish translations of instructions developed in 2009 nationally standardized) of the Wechsler Adult Intelligence Scale-IV (WAIS-IV: Wechsler, 2008), and the Achenbach Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001). Parental assessment for health literacy will be assessed by the Test of Functional Health Literacy in Adults (TOFHLA) developed and validated in the literacy of health Care Project (Cronbach’s alpha 0.96-0.98). Within a month of testing, participants will receive a letter with the test results including recommendations and anticipatory guidance on developmental milestones. Effectiveness Evaluation: At the beginning of each session, the educator will document any lead- or respiratory health-related services reported by the participant. The curriculum includes a pre- and post-lead Exposure and Asthma Triggers Knowledge Test, which will assess any changes in lead and asthma. Follow-up Assessments: Baseline assessments will be repeated after three, six and twelve months.

This project meets the Region 6 waiver goals for the following:
- **Triple Aim:** assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the healthcare infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improved outcomes while containing cost growth

We shall continually assess the quality improvement and project impacts, and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Starting Point/Baseline:**

1. **Number of Patients Served in Previous Department of Pediatrics Lead and Asthma Projects:** In the 2004 project 325 mothers and infants (total served 1300) were served and in the 2009-2011 project 212 (total served 848) children and parent members were served.

2. **Percent of Providers Trained in Intervention:** 100% of the Community Pediatrics Medical,
Psychological and Health Navigator/Health Educators are fully trained. In like manner, 100% of the Family Medicine staff Medical, Environmental health inspectors and Environmental technicians are fully trained and proficient in each of their fields of expertise.

2. **Number of Patients Served in Previous Department of Family Medicine Projects.**

(a) National Institute of Environmental Health Sciences Environmental House-call Pilot Study: (2000-2001). Comprehensive environmental testing was performed for 15 family units (total served 60 units); (b) U.S. Housing Urban Development (2006-2009). Healthy Homes Project Comprehensive environmental testing for 60 homes and family units (total served 240). Families reported a decrease in emergency room visits, decrease asthma severity of over the course of the year and reduction in school absenteeism related to asthma and (c) Centers for Disease Control CDC/ATSDR Border Environmental Health and Toxicology Education Research Program with Texas A&M Univ. School of Rural Public Health (2009-2012). In-home asthma educational sessions for 145 low-income Hispanic families conducted.

**Rationale:**

The Integrated Primary and Behavioral Medical Lead Poisoning and Asthma Intervention & Prevention option was selected because asthma and lead represent tremendous health and growth and development problems, not only in Bexar County, but in the state of Texas. Project components including all required core components already secured for the successful implementation of the project include provider agreements, project protocols, recruitment and enrollment procedures, an identified target population awaiting enrollment, project staff recruitment, community and HUD collaborators’ endorsements, and necessary hospital affiliations. This project is a new initiative, integrating innovative and preventive healthcare delivery through existing and successful collaborations and partnerships throughout the community and across federal agencies. This project includes qualitative and quantitative data collection for biological, psychological, quality of life, patient health literacy data and environmental health quantitative outcome data. This project addresses care for children with asthma and childhood lead poisoning--which represent major health disparities in our community.

The unique community need identification numbers the project addresses:

- **CN.4** There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.
- **CN.1** The need to deliver improved lead and asthma health care compliance, quality of life and literacy.

**Related Category 3 Outcome Measure(s):**

The rationale for selecting Primary Care Behavioral Health for lead exposed and asthmatic children.

1. Asthma is a chronic health problem for children and is the leading cause of hospital visits for children. In like manner, lead poison is a high priority concern for children in South Texas.
2. Reports from the Texas Department of State Health Services and San Antonio 2011 Needs Assessment, document these health problems and health disparities among impoverished
children.

3. The 2011 Centers for Disease Control and Prevention health advisory committee recommends primary care and home based care in conjunction with preventive education.

<table>
<thead>
<tr>
<th>Relationship to other Projects:</th>
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<tbody>
<tr>
<td><strong>Project Support, Reinforces and Enables other Project Interventions.</strong> The proposed “The Integrated Primary and Behavioral Medical Lead Poisoning and Asthma Intervention &amp; Prevention” is commensurate with the HUD-funded San Antonio Green and Health Homes funding and the UTHSC Family Medicine and Pediatrics environmental health comprehensive services research agenda... Asthma is a major problem that affects neurological, endocrine logical, psychological and psycho-educational and overall growth and development of children and especially poor and minority children.</td>
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<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
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<tbody>
<tr>
<td>The Departments of Family and Community Medicine and Pediatrics (Division of Community Pediatrics) are not aware of any UTHSCSA or community providers that are submitting Lead and Asthma or other environmental health related research.</td>
</tr>
</tbody>
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<tr>
<th>Plan for Learning Collaborative:</th>
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<tbody>
<tr>
<td><strong>Plan for participating in a RHP-wide learning collaborative:</strong> Community Pediatrics and Family Medicine submitted research grants in 2005 and 2011 to the U.S. Department of Housing and Urban Development (HUD) in order to address the Lead poison and Asthma health care problem in children. We were funded in the 2005 application. Currently, Community Pediatrics is serving as a consultant to the 2011 San Antonio Green and Healthy Homes Initiative (S.A GHHI) and through collaboration with the city. Community Pediatrics and Family Medicine will develop a research agenda to continue Lead and Asthma research.</td>
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<tr>
<th>Project Valuation:</th>
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<tr>
<td>Project Evaluation will include a cost analysis. A database will be designed to tract the number of clients served, types of services received and quantitative as-well-as qualitative measure will be collected. A power analysis will be conducted to find the number of clients needed to find significant changes in E.R. visits. Chi-square tests, <em>t</em>-tests, and analyses of variance (ANOVA) will be conducted to compare differences between the dependent variable with respect to number and types of encounters/interventions. Univariate ANOVAs will be used to assess whether the independent variables used had significant main effects on test scores and also to determine whether an interaction effect occurred between the Independent Variable and Dependent Measures. A regression analysis for each dependent measure will identify demographic and psychosocial variables as covariates in subsequent hypothesis testing of E.R visits. Associations between the demographic covariates (age, gender, and ethnicity), treatment use covariates (e.g. age of first use of any medication and age of first asthma), and the independent and dependent variables will be examined using Pearson correlation coefficients, <em>t</em>-tests, and ANOVAs. The Wilks’ lambda statistic will assess the proportion of error and of the effect variance/covariance in the dependent variables unaccounted for by the independent variables. Multivariate Analysis of Variance (MANOVA) and Multivariate Analysis of...</td>
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Covariance (MANCOVA) will be used to test the relationship between Independent variables and the dependent measures while controlling for age, treatment history and other variables such as; ethnicity, and gender.

**Cost Benefit Analysis:** In a study referencing the economic value of home-based, multi-trigger, multi-component interventions with an environmental focus for reducing asthma, Nurmagambetov et al. (2011) found that for every dollar spent on the intervention, the monetary value of the resulting benefits, such as averted medical costs or averted productivity losses was $5.30–$14.00 (the benefit-cost ratio). Each additional symptom-free-day had a cost-effectiveness ratio between $12–$57. Cloutier et al. (2009) found that with an asthma management program that reduces asthma-related health services utilization there is a potential $3.58 return on investment per each US dollar spent for Medicaid managed care plans.
<table>
<thead>
<tr>
<th>085144601.2.1</th>
<th>2.7.6</th>
<th>NA</th>
<th>2.7.6 Implement innovative evidence based strategies to significantly reduce and prevent lead poisoning and asthma in children and adolescents by targeting environmental aspects of children’s health (TEACH)</th>
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</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td>Related Category 3</td>
<td>Outcome Measure(s): 085144601.3.18 IT-9.3 Pediatric / Young Adult Asthma Emergency Department Visits</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X] Recruit and train all project staff to implement an innovative evidence based client and health systems level interventions/prevention program. Metric[P-X.1]: staff recruited and trained within 90 days Numerator: Number of staff trained. Denominator: Total staff participating Goal: 100% of participating staff trained Data Source: HR Records and training materials Milestone 1 estimated incentive value: $661,050</td>
<td><strong>Milestone 3</strong> [P-X] Execution of intervention and prevention of asthma/lead environmental antagonist for cohort 1. Metric [P-X.1]: 491 Medicaid eligible children enrolled in Asthma/Lead intervention program. Numerator: Number of patients enrolled in program Denominator: Number of patients tested and qualifying for enrollment in cohort 1. Goal: 491 patients successfully enrolled in program. Data Source: EMR, and Green Health Homes Database Milestone 3 Estimated Incentive Payment:$362,957</td>
<td><strong>Milestone 7</strong> [I-X] Quality review to assess successes, challenges and best practice. Metric [I-X.1] Complete quality review for 785/982 80% of program enrollees. All bio-measures, environmental measures, and psychosocial measures completed and populated into database. Numerator: Number of quality review examinations performed on cohort 1 and cohort 2 program participants Denominator: total number of program participants Goal: 785/ 982 program participants reviewed. (80%) Data Source: Health Science Center Database. Milestone 7 Estimated Incentive Payment: $500,200</td>
<td><strong>Milestone 8</strong> [P-X] Implement environmental &amp; patient biomarker and psychosocial and lead/asthma quality of life base line assessments for cohort 3. Metric[P-X.1]: 491 environmental (blood test) and psychosocial measures administered (3 measures) Numerator: Number of biomarker and psychosocial tests administered cohort 3 Denominator: Number of qualifying candidates cohort 3 Goal: 491 or 100% of qualifying candidates tested. Data Source: Medical records and Green Healthy Home database. Milestone 8 Estimated incentive payment: $500,200</td>
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**Milestone 2** [P-X] Implement environmental & patient **Milestone 4** [P-X] Implement
<table>
<thead>
<tr>
<th><strong>Milestone 1</strong></th>
<th><strong>Milestone 2</strong></th>
<th><strong>Milestone 3</strong></th>
<th><strong>Milestone 4</strong></th>
<th><strong>Milestone 5</strong></th>
<th><strong>Milestone 6</strong></th>
<th><strong>Milestone 7</strong></th>
<th><strong>Milestone 8</strong></th>
<th><strong>Milestone 9</strong></th>
<th><strong>Milestone 10</strong></th>
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| [P-X.1] Execution of intervention and prevention of asthma/lead environmental antagonist for cohort 1.  
Metric [P-X.1]: 491 environmental and psychosocial measures administered (3 measures)  
Numerator: Number of biomarker and psychosocial tests administered cohort 1  
Denominator: Number of qualifying candidates cohort 1  
Goal: 491 or 100% of qualifying candidates tested.  
Data Source: Medical records and Green Healthy Home database.  
Milestone 2 Estimated incentive payment: $661,050 | Environmental & patient biomarker and psychosocial and lead/asthma quality of life base line assessments for the 2nd cohort.  
Metric [P-X.1]: 491 environmental (blood test) and psychosocial measures administered (3 measures)  
Numerator: Number of biomarker and psychosocial tests administered cohort 2  
Denominator: Number of qualifying candidates cohort 2  
Goal: 491 or 100% of qualifying candidates tested.  
Data Source: Medical records and Green Healthy Home database.  
Milestone 4 Estimated incentive payment: $362,957 | Environmental & patient biomarker and psychosocial and lead/asthma quality of life base line assessments for the 3rd cohort.  
Metric [P-X.1]: 491 environmental (blood test) and psychosocial measures administered (3 measures)  
Numerator: Number of biomarker and psychosocial tests administered cohort 3  
Denominator: Number of qualifying candidates cohort 3  
Goal: 491 or 100% of qualifying candidates tested.  
Data Source: Medical records and Green Healthy Home database.  
Milestone 6 Estimated incentive payment: $500,200 | Environmental & patient biomarker and psychosocial and lead/asthma quality of life base line assessments for the 4th cohort.  
Metric [P-X.1]: 491 environmental (blood test) and psychosocial measures administered (3 measures)  
Numerator: Number of biomarker and psychosocial tests administered cohort 4  
Denominator: Number of qualifying candidates cohort 4  
Goal: 491 or 100% of qualifying candidates tested.  
Data Source: Medical records and Green Healthy Home database.  
Milestone 8 Estimated incentive payment: $1,553,121 | Execution of intervention and prevention of asthma/lead environmental antagonist for cohort 3.  
Metric [P-X.1]: 491 Medicaid eligible children enrolled in Asthma/Lead intervention program.  
Numerator: Number of patients enrolled in program  
Denominator: Number of patients tested and qualifying for enrollment in cohort 3.  
Goal: 491 patients successfully enrolled in program.  
Data Source: EMR, and Green Health Homes Database  
Milestone 9 Estimated incentive payment: $500,200 | Execution of intervention and prevention of asthma/lead environmental antagonist for cohort 4.  
Metric [P-X.1]: 491 Medicaid eligible children enrolled in Asthma/Lead intervention program.  
Numerator: Number of patients enrolled in program  
Denominator: Number of patients tested and qualifying for enrollment in cohort 4.  
Goal: 491 patients successfully enrolled in program.  
Data Source: EMR, and Green Health Homes Database  
Milestone 10 Estimated incentive payment: $500,200 |
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<tr>
<th>Milestone 5</th>
<th>Estimated incentive payment: $362,957</th>
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</thead>
<tbody>
<tr>
<td>Participants enrolled in program Denominator: Number of patients tested and qualifying for enrollment in cohort 2. Goal: 491 patients successfully enrolled in program. Data Source: EMR, and Green Health Homes Database</td>
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<tr>
<th>Milestone 6</th>
<th>Estimated incentive payment: $362,957</th>
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<tr>
<td>[P-X] Execution of evaluation process for project innovation. Project Outcomes and Data analysis. Metric [P-X.1] Complete initial and second visit of individuals and their ED utilization cohort 1. Numerator: Number of evaluations completed cohort 1 Denominator: Number of individuals enrolled in program Goal: 333 or 67% of evaluations completed cohort 1 Data Source: Health Science Center Medical records</td>
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<tr>
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<tr>
<th>Milestone 10</th>
<th>Estimated incentive payment: $500,200</th>
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<tbody>
<tr>
<td>Participants completed and populated into database. Numerator: Number of quality review examinations performed on cohort 3 program participants Denominator: total number of program participants cohort 3. Goal: 391/491 program participants reviewed. (80%) Data Source: Health Science Center Database.</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone</td>
<td>Year 3 Estimated Milestone</td>
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<tr>
<td>Bundle Amount: $1,322,101</td>
<td>Bundle Amount: $1,451,830</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,827,652**
**Identifying Project and Provider Information:**

<table>
<thead>
<tr>
<th>Title: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 085144601.2.2 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: The University of Texas Health Science Center at San Antonio</td>
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<tr>
<td>Performing Provider TPI: 085144601</td>
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**Project Summary:**

- **Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

- **Intervention(s):** The project will place master’s level behavioral care managers (BCM) in primary pediatric clinics to work with children with ADHD and comorbid psychiatric conditions (depression, aggression), providing behavioral and family therapy. The BCM will consult with child psychiatrists who in turn will assist pediatricians with psychopharmacology when needed. The BCM’s and child psychiatrists will provide crisis counseling as well.

- **Need for the project:** Currently child in pediatric primary care with ADHD may wait months for an appointment with mental health professional or child psychiatrists, untreated illness often leads to severe crises which result in hospitalization and increased medical costs.

- **Target population:** In December 2011, there were approximately 1400 served in the primary care pediatric clinics and 3000 served in pediatric specialty clinics of the University of Texas Health Center Health Science Center (UTHSCA). Roughly 50% of these children (n =2200) would be in the age of risk for ADHD (> 3 years) on epidemiological data, 10% of these children would meet criteria for ADHD (n = 200). Approximately 10 of these would have severe conditions requiring psychiatric hospitalization or involvement of the police each month. Thus 80-120 per year might require such a level of intervention. This population is entirely indigent/Medicaid eligible.

- **Category 1 or 2 expected patient benefits:** Perform 200 visits/month with children with ADHD and severe comorbid disorders in the PROXIMA program. This will involve up to 1200 unique patients per year. Number of patients per DY: DY2:300, DY3:800, DY4:1200, DY5:1200

- **Category 3 outcomes:** 50% reduction is baseline rate of psychiatric hospitalization (80-120 admissions per year) of children with ADHD and severe comorbidity.

**Project Description:**

PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD) is an integrated mental and physical health program for children with ADHD and related disorders. Master level mental health providers will be placed in primary and specialty care clinics of the Pediatrics Dept. of UTHSCSA. These Behavioral Care Managers (BCM) will conduct assessments with children with suspected ADHD, integrate diagnostic information from home and school, provide psychoeducation about ADHD as well as behavior management...
regarding not ADHD but aggression, mood regulation and sleep. A child and adolescent psychiatrist (CAP) will consult with both the BHC and the PCP. The CAP will guide the PCP in the use of expanded psychopharmacology for complex cases of ADHD, reducing need for specialty referral and psychiatric hospitalization. Since CAP residents and pediatric residents currently train in isolation from each other, PROXIMA will fund time for residents of both specialties to do joint rotations to enhance consulting and communication skills.

This project meets the Region 6 waiver goals for the following:

- **Triple Aim**: assuring patients receive high-quality and patient-centered care, in the most cost effective ways
- Improve the healthcare infrastructure to better serve the Medicaid and uninsured residents of our counties
- Further develop and maintain a coordinated care delivery system
- Improved outcomes while containing cost growth

In order to pursue quality improvement we shall continually assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Starting Point/Baseline:**

In December 2011, there were approximately 1400 served in the primary care pediatric clinics and 3000 served in pediatric specialty clinics of the University of Texas Health Center Health Science Center (UTHSCSA). Roughly 50% of these children (n =2200) would be in the age of risk for ADHD (> 3 years) on epidemiological data, 10% of these children would meet criteria for ADHD (n = 200). Approximately 10 of these would have severe conditions requiring psychiatric hospitalization or involvement of the police. Thus 80-120 per year might require such a level of intervention.

**Rationale:**

Attention-deficit/hyperactivity disorder (ADHD) affects 6-9% of school-age youth in the U.S., and is the most prevalent psychiatric disorder among preadolescents. ADHD’s adverse impact on learning, self-control, and personal safety are well-established. The large subgroup with comorbid disruptive behavior disorders (DBDs) also incurs the disadvantages of persistent antagonistic behavior, such as embittered family relations and social exclusion. Beyond childhood, ADHD raises the incidence or severity of many mental health problems, especially those distinguished by poor impulse control (e.g., antisocial behavior, affective dysregulation, and substance abuse).

- The challenges of working with this population is a high no show rate for mental health care (25-30% in UTHSCSA child psychiatry clinics and a tendency toward coming to appointments only in a crisis). There is a stigma around seeking mental health care. PROXIMA will implement and evaluate a collaborative-care model (for ADHD within primary pediatric services). This addresses the challenge by providing care in a setting comfortable to families and that is readily accessible. The five year outcome will be reduced need for hospitalization and improved psychosocial functioning as assessed by standardized measures. Improved outcome for children with ADHD with integrated care has been shown by numerous studies (http://www.skipproject.org/).
**Unique Community Need-Mental Health Among Youth.** At present, about 40% of Bexar County’s population is under the age of 21 or 640,000 individuals. (pg 9 of Community Health Assessment, CHA). Given that up to 10% of these individuals have ADHD and 14% “seriously considered suicide (these are likely overlapping populations), this means more than 60,000 youth are at risk. Only 1501 received state mental health services (Figure 277, CHA) and while many others received care in the private sector, many low income youth with ADHD and other comorbid conditions have gone untreated.

**Overview of PROXIMA.** While PROXIMA is a new program for the Performing Provider, the Divisions of Child Psychiatry and Pediatrics have recently completed a four year state wide project, Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT) which placed Master level mental health practitioners in primary care settings. SUPPORT showed that after six months, participants showed significant improvement in ratings of quality of life and behavioral/emotional functioning. PROXIMA will provide a Behavioral Care Manager (BCM), supervised by a child psychiatrist, who supports primary care physicians in assessment and optimized management of ADHD. The BCM will be a licensed master's level mental health professional. BCMS’ roles include family psychoeducation, treatment planning, and frequent outcome measurements, decision-support for a data-driven medication algorithm, psychosocial therapies, assiduous patient follow-up, and supporting families’ engagement with treatment. By early intervention with children with ADHD in the primary care setting, we hope to limit negative outcomes such as psychiatric hospitalization and antisocial behavior which often leads to involvement in the juvenile justice system.

Eligible children are 5-15 years-old who are (a) referred from primary care clinicians (PCPs) for suspected ADHD, both with and without concurrent aggression, conduct or mood disorders.

PROXIMA will occur in the primary and specialty (chronic care) clinics of the Department of Pediatrics of the UTHSCSA. Up to five BCM’s will be employed, in each of the high volume pediatric clinics in San Antonio. These clinics routinely refer out 5-10 individuals a week with ADHD and related conditions, most of these end up on waiting lists in local mental health agencies. PROXIMA will allow immediate intervention in the primary care setting.

The BCM meets with the project team’s child psychiatrist for weekly supervision. In the primary care setting, the BCM is part of the practice’s team. Each practice also has a liaison pediatrician who participates in monthly project reviews with the study team and ensures smooth implementation at the pediatric site.

Prior to meeting with a family allocated to PROXIMA, the BCM reviews the assessment information with the site’s psychiatrist and the RC. Preliminary suggestions for initial management are proposed for subsequent review by the family and PCP, with attention to factors that may disfavor the first-line medication and behavioral intervention approaches (e.g., stimulant intolerance, tics, factors that may warrant modifying behavioral therapy). When needed for diagnosis or treatment planning, other information will be identified and obtained. The BCM discusses the family’s chief concerns, and offers a summary of the history from review of the evaluation, inviting parents to clarify and elaborate. The role of ADHD as a contributor to the child’s difficulties will be introduced, along with factors/comorbidities as indicated. Parents’ ratings of ADHD and other behavioral symptoms will usually be a good starting point. The BCM will use and give families printed and video materials (available in English and Spanish) from the AAP ADHD Toolkit, AACAP, and other sources from the
common library we establish. Families’ treatment preferences, attitudes toward medications, and pressures they experience from extended family members around their child’s needs are discussed. The BCM helps parents to record specific questions about risks and benefits of medications to ask the PCP. The BCM acquaints parents with the main outcome monitoring tools, described next, and the importance of the information they yield to gauge progress.

Child psychiatrists will consult on the selecting the particular stimulant and dosing strategy for a particular child. The BHC will assist the physicians by obtaining rating scales from the parent and school. After stimulant optimization steps, not all children will experience sufficient amelioration of symptoms. We distinguish between significant residual difficulties that are chiefly core symptoms of ADHD, for which additional medications will be familiar to PCPs, and those that reflect comorbid problems such as aggression, anxiety, and mood disturbances, for which more direct care by a child psychiatric specialist is indicated. In consultation with the psychiatrist, we anticipate that PCPs will typically initiate alternate or adjunctive medication when the chief concern is persistence of ADHD symptoms.

Symptoms of ADHD and comorbid problems that persist beyond these initial steps often warrant treatments beyond the comfort zone of most PCPs. While always an option, we anticipate common scenarios for assessment by the team’s psychiatrist. (a) Related disruptive behavior symptoms, such as aggression, temper dyscontrol, or conduct problems that often improve with ADHD treatment, but nonetheless remain to a detrimental extent, may require pharmacotherapy or more intensive behavioral interventions. (b) Anxiety and mood problems may require more specific treatment. (c) Poor tolerance for pharmacotherapy or atypical responses to it may compel diagnostic reconsideration.

Most evidence-based psychosocial treatments for youngsters with ADHD focus on associated conduct problems, such as difficulties with rule-adherence, complying with directions, managing frustration and anger, etc. The core of the behavioral treatments are: 1) introduction and goal setting; 2) increasing positive interactions with the child, noticing and rewarding cooperative behavior and self-containment when frustrated, and structuring the environment and routines to avert problem behavior; 3) tools to maintain parental composure in the face of difficult behavior, including judicious ignoring of low-level misbehaviors to avoid unnecessary conflicts and inadvertent reinforcement via attention; 4) tools to help parents communicate to the child directions and other limits on behavior that hitherto resulted in combative reactions; 5) implementation of a system to provide behavioral monitoring, clarity of expectations and consequence to reward cooperation and improved frustration tolerance; 6) implementation of a similar school behavioral program in consultation with teachers; 7) interventions for handling uncooperative and dyscontrolled behavior.

PROJECT COMPONENTS:
- (A) We have identified sites (University Health System [UHS Pediatric Clinics, affiliated with UTHSCSA) to be involved in the program.
- (B) As UHS is a primary teaching hospital for UTHSCSA, agreements can be efficiently negotiated.
- (C) Establish protocols and processes for communication, data sharing, and referral between behavioral and physical health providers.
- (D) Pediatricians in the Community Medicine Associates of UHS and UTHSCSA Dept of Pediatrics (faculty and residents) will be recruited to participate.
- (E) Train physical and behavioral health providers in protocols, effective communication and
team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:

- Regular consultative meetings between physical health and behavioral health practitioners;
- Case conferences on an individualized as needed basis to discuss individuals served by both types of practitioners; and/or
- Shared treatment plans co-developed by both physical health and behavioral health practitioners.

(F) We will develop agreements to access Electronic Health Record (EHR) data from UHS (Sunrise) as well as develop a method to track hospitalization via Medicaid claims.

(G) Since UHS and UTHSCSA are already health care partners, legal issues are not anticipated to be significant in terms of limiting collaboration.

(H) All utilities/building services are in place.

(I) We will develop a web based tool to track progress using standardized mental health symptom rating scales.

(J) We will regularly conduct Quality Improvement to identify challenges and barriers to working with this population or that prevent true collaboration.

CN.4 This project addresses the need for high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

CN.1. This project addresses the need for improved health care quality in our community.

**Related Category 3 Outcome Measure(s):**

- Psychiatric hospitalizations of children with ADHD and complex comorbidities (aggression, mood disorder) have risen dramatically in Texas and nationwide. These admissions occur in crisis and rarely result in long term outpatient care to consolidate any gains. Thus, there is often little long term benefit despite high costs.
- PROXIMA will seek to reduce potentially preventable admissions (PPA, OD-2) through provision of integrated mental/physical health services.
- Process Milestones for Outcome: **Milestone 1** will be to engage stakeholders (pediatricians, community) to ensure PROXIMA program meets the challenges these families present. **Milestone 2** will establish the baseline rate of psychiatric hospitalization. **This is a customized milestone critical to accurate assessment of our Improvement Target.** **Milestone 3** will be to test data collection procedures, while **Milestone 4** will be to conduct Plan Do Study Act (PDSA). We choose reduced hospitalization as our **Improvement Target** due to the high cost of hospitalization and the lack of evidence that acute hospitalization improves long term functioning.

**Relationship to other Projects:**
It will be key for the PROXIMA project to be integrated with other child health providers in the region, as well as schools. Children in this population are likely to have variety of neurodevelopmental (autism spectrum and learning disorder) and social issues that will need intervention outside the primary care clinic. When children do need hospitalization, coordination of treatment planning and follow up services will be integrated to prevent gaps in care. A project related to PROXIMA is TEACH (Targeting Environmental Aspects of Children’s Health – 2.15.2), which also integrates primary care and behavioral health for children with a team approach to care.
**Relationship to Other Performing Providers’ Projects in the RHP:**

None of the other projects are proposing an integrated primary and behavioral health system for children, though one other project (UTHSCSA, 2.15.1) will do so in adults. This project, along with the two projects mentioned above (Clarity, CHCS) will be included in a learning collaborative.

**Plan for Learning Collaborative:**

A weekly phone conference will focus on identifying patients shared by the providers and addressing the challenge of obtaining permission form parent to share children’s data amongst the providers. The Dept of Psychiatry developed a web-based simple database as part of an earlier practice to track data across practices. Information from the BHC’s on patients’ will be used to identify common barriers to continuity of care and follow through. This information will be rapidly disseminated to all sites and a webinar based brain storming session will carried out to propose ways of dealing with these barriers. Pilot projects will be launched and the results (i.e., reduction in drop-out from treatment) disseminated to sites. Quarterly in person meeting will be held amongst the partners. Families will be asked if they wish to speak of their experience in PROXIMA, with quotes of successful outcomes disseminated each week to encourage staff of PROXIMA to preserve in their efforts. Successful interventions will be mandated in all the practices using PROXIMA.

**Project Valuation:**

In 1982 Satterfield and colleagues reported an 8 year follow up of 110 boys with ADHD (mean age 17). 58% of low income boys with ADHD had a conviction for a serious offense compared to 11% of low income boys without ADHD. While children are never admitted to a psychiatric facility for symptoms of ADHD alone, 1 in 5 children with ADHD have severe comorbidity such as mood disorder or severe aggression which leads to dangerous behavior to self or others. Incarceration in a juvenile justice facility may cost $100 per day, such that long term costs may be in excess of $40,000 per year. A typical psychiatric hospitalization may cost $1,000 per day for 5-10 days (~$7,500). In the baseline data we noted that 10 youth per month need inpatient care. Assuming 80 youth per year from our sample needing institutional care of some sort, the cost of caring for this cohort would be:

- 20 youth in long term juvenile care: $800,000 per year
- 20 youth with short term juvenile detention stays: $90,000 per year
- 40 youth with 1.5 psych admissions per year $450,000 per year

Total: $1,340,000 per year

Other costs of under treated ADHD are increased special education services, demands on the juvenile courts for truancy can be estimated to be about $260,000 per year for the entire cohort. Thus our population would account for $1.6 million in costs per year, or $6.4 million over 4 years. The total cost of PROXIMA would be $4 million for all four years, a significant savings.
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<tr>
<th>085144601.2.2 PASS 1</th>
<th>2.15.1</th>
<th>2.15.1 (A, C, E)</th>
<th>2.15.1 Design, implement, and evaluate projects that provide integrated primary and Behavioral health care services: PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD)</th>
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<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 0855144601</td>
<td>Related Category 3 Outcome Measure(s): 085144601.3.19 3.1T-2.4</td>
<td>Behavioral health/substance abuse admission rate</td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 4</strong></td>
<td><strong>Milestone 7</strong></td>
<td><strong>Milestone 10</strong></td>
</tr>
<tr>
<td>[P-2] Identify existing clinics/community based settings (UTHSCSA primary care, private practice) where integration could be supported. Metric P2.1 Discussion with community health care providers, nonprofit health care agencies Establish number of patients and need. Data Source: Healthcare professional, stakeholder opinion, EMR data from clinics Milestone 1 Estimated Incentive Payment: $406,800</td>
<td>[P-6]: Develop integrated behavioral health and primary care services with in collocated sites Metric 1 [P-6.1]: Number of providers achieving level 4 interaction Baseline/Goal 0/15 Data Source: Project Data Milestone 4 Estimated Incentive Payment: $446,717</td>
<td>[I-8]: Integrated Services Metric 1 [I-8.1]: Number of individuals receiving both physical and BH at locations Baseline/Goal: 0/1200 Data Source: Project data, EHR, claims Milestone 7 Estimated Incentive Payment: $477,833.33</td>
<td>[I-8]: Integrated Services Metric 1 [I-8.1]: Number of individuals receiving both physical and BH at locations Baseline/Goal: 0/1200 Data Source: Project data, EHR, claims Milestone 10 Estimated Incentive Payment: $477,833.33</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
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<tr>
<td>[P-5]: Develop integrated sites reflected in the number of locations and providers</td>
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</tbody>
</table>

**Milestone 5**

[P-9]: Review Project Data and respond to it every week with tests of new ideas. Metric 1 [P-9.1]: Number of new ideas, practices, tools or solutions tested by provider. Goal: Produce rating scales, |

**Milestone 6**

[I-11]: Health Metrics Metric 1 [I-11.1]: Clinically significant change in standardized measure Goal: Change in Total Behavior Problem Score on the Child Behavior Checklist (CBCL) |

**Milestone 8**

[I-11]: Health Metrics Metric 1 [I-11.1]: Clinically significant change in standardized measure Goal: Change in Total Behavior Problem Score on the Child Behavior Checklist |
<table>
<thead>
<tr>
<th>Metric 1 [P-5.3]:</th>
<th>therapy types, patient follow through measurements. Data Source: Description summarized at quarterly meetings Milestone 5 Estimated Incentive Payment: $446,717</th>
<th>Milestone 8 Estimated Incentive Payment: $477,833.33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of behavioral health providers located in behavioral health settings. Baseline/Goal: 0/5 Data Source: Project Data</td>
<td></td>
<td>Milestone 9 Estimated Incentive Payment: $477,833.33</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $406,800</td>
<td></td>
<td>Milestone 11 Estimated Incentive Payment: $477,833.33</td>
</tr>
<tr>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 6</strong></td>
<td><strong>Milestone 12</strong></td>
</tr>
<tr>
<td>[I-8]: Integrated Services Metric 1 [I-8.1]: Number of individuals receiving both physical and BH at locations Baseline/Goal: 0/300 Data Source: Project data, EHR, claims</td>
<td>[I-8]: Integrated Services Metric 1 [I-8.1]: Number of individuals receiving both physical and BH at locations Baseline/Goal: 0/800 Data Source: Project data, EHR, claims</td>
<td>[I-11]: Health Metrics Metric 1 [I-11.1]: Clinically significant change in standardized measure Goal: Change in Total Quality of Life Score on the Pediatric Quality of Life Scale (PedsQL) Data Source: Project Data Milestone 9 Estimated Incentive Payment: $477,833.33</td>
</tr>
<tr>
<td>Milestone 3 Estimated Payment: $406,800</td>
<td>Milestone 6 Estimated Payment: $446,717</td>
<td>Milestone 12 Estimated Incentive Payment: $461,722.33</td>
</tr>
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</table>

**Year 2 Estimated Milestone Bundle Amount**: $1,220,401

**Year 3 Estimated Milestone Bundle Amount**: $1,340,151

**Year 4 Estimated Milestone Bundle Amount**: $1,433,650

**Year 5 Estimated Milestone Bundle Amount**: $1,385,167

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $5,379,369
**Identifying Project and Provider Information:**

<table>
<thead>
<tr>
<th>Title: 2.13.2 Implement other evidence-based project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 085144601.2.3 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: The University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Dawn I. Velligan Ph.D. Pedro Delgado M.D.</td>
</tr>
<tr>
<td>Performing Provider TPI: 085144601</td>
</tr>
</tbody>
</table>

**Project Summary:**

**Provider Description:**

The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** The project provides evidence-based transitional care for individuals discharged from psychiatric units or diverted from emergency rooms. Interventions to be delivered include cognitive behavior therapy (a treatment focused on correcting errors in attribution and thinking in an effort to improve outcomes in depression, anxiety and psychosis); cognitive adaptation training (a home based treatment using environmental supports such as signs, alarms, checklists, pill containers to promote medication adherence and improve community functioning); family psychoeducation and care coordination (designed to link patients to appropriate options for care in the community for longer term follow up). A unique feature of this program is that it provides interprofessional training in these evidence-based approaches for social workers, nurses, and case workers to improve workforce development as well as community behavioral health training for prescribing professionals—physicians, advance practice nurses and physician assistants.

**Need for the project:** There is a severe shortage of mental health providers in Bexar county coupled with reduced availability of services for the most seriously mentally ill—overwhelming existing health care systems, dramatically increasing the use of emergency services and leaving the most vulnerable in our society with inadequate or no mental health care options. This project increases service availability and delivery and develops the workforce for multiple disciplines for work with the seriously mentally ill.

**Target population:** Seriously mentally ill being discharged from inpatient psychiatry units or diverted from emergency services.

**Category 1 or 2 expected patient benefits:** Enroll and provide evidence-based services for over 4600 individuals in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual prior and ensuring connection with longer-term services in the community. Training a minimum of 40 new providers (10 per year) in application EBPs for the seriously mentally ill using an inter-professional treatment model that is easily replicable throughout Texas.

**Category 3 outcomes:** Our goal is to reduce the potentially preventable all-cause readmission.
rate within in 1 year by 20% in DY4 and 30% in DY5.

Project Description:
The costs of serious mental illness (SMI) are $317 billion annually, or more than $1,000/year for every man, woman, and child in the U.S. The 2010 Community Health Assessment of Bexar County found that 32% of residents have no usual source of health care. For those who do, transportation issues and cost issues, including underinsurance, often lead to a delay in seeking care. Other barriers include a lack of knowledge of community services, lack of access to those services and a lack of localized services. According to a 2011 report by Capitol Healthcare Planning, a severe shortage of mental health providers in the area coupled with reduced availability of services for the most seriously ill have combined to overwhelm existing health care systems and leave the most vulnerable in our society with inadequate or no mental health care options. This situation has led to a dramatic increase in the use of emergency services by patients who have not been able to obtain timely appointments in community agencies or have no other place to go for help. Even when resources exist, mental health providers are frequently not available. To address these needs the Department of Psychiatry has developed a Transitional Care Clinic (TCC) designed to give patients rapid access to a prescriber upon hospital discharge or diversion from emergency departments (ED) and provide gap services and linkage to community services for a period of up to 90 days. The TCC also functions as a specialty training program in community psychiatry training residents and nurse practitioners with the goal of increasing the number of providers in the underserved South Texas area. However, in addition to medication, the patients coming out of emergency departments and psychiatric units need access to rapid wrap around care including prescription medications, specialized behavior therapies, psychosocial rehabilitation, skills training, transportation and case management. Those patients who are deemed "priority population" including those with psychosis and bipolar I disorders can eventually qualify for wrap-around services through the local mental health authority, but cannot qualify to receive these services until they have completed the required Texas assessment (TRAG). These patients are essentially "unfunded" until they can be assessed and assigned to a clinic which may take a number of months. They are left vulnerable to relapse and readmission in the critical days immediately following discharge/diversion. Many other patients with recent suicide attempts, severe anxiety or depression, are not priority population and will remain unfunded for services until a solution is found. The critical period post discharge or diversion is a period in which aggressive wrap around services can prevent deterioration and readmission.

The Transitional Care Clinic (TCC) began providing gap services including medication management, case management, skills training, and psychotherapy in an innovative inter professional setting on 4/2/12. Currently, there are over 200 active patients in the 90 day program funded by a private foundation grant. No federal money funds the TCC. The majority of patients have no health care benefits upon admission. The TCC provides comprehensive wrap around transitional services including; cognitive behavior therapy (a treatment focused on correcting errors in attribution and thinking in an effort to improve outcomes in depression, anxiety and psychosis); cognitive adaptation training (a home based treatment using environmental supports such as signs, alarms, checklists, pill containers to promote medication adherence and improve community functioning); family psychoeducation and care coordination (designed to link patients to appropriate options for care in the community for longer term follow up). Patients are connected for follow up at the Center for Health Care Services, FQHCs, the University Health System outpatient clinic, UTHSCSA psychiatry clinic, other MHMR clinic’s outside the county or private providers. A unique feature of this program is that it provides
interprofessional training in these evidence-based approaches for social workers, nurses, and
case workers to improve workforce development as well as community behavioral health
training for prescribing professionals—physicians, advance practice nurses and physician
assistants. Our Division of Schizophrenia and Related Disorders is a world-leader in developing
and testing EBPs for the SMI population. The TCC will provide critically needed services and
increase the number of providers trained in this model. The program will develop a referral
mechanism accessible on a secure internet site to be used by all local hospital emergency rooms
and inpatient psychiatric units in the Bexar county area, allowing for rapid assessment of need
and triage to most appropriate type of service. An Outreach Coordinator serves as a liaison
between referral sites and the TCC as well as from TCC to community resources. Evidence from
a pilot study with Superior Medicare found that our wrap around services cut hospitalizations for
frequent service utilizers in half and saved more than $20,000 per patient in 9 months. Wrap
around services immediately following hospital admission or emergency room contact, can
prevent a return to these costly services. In a community where 32% of the population has no
usual source of care and little knowledge of community resources, a program that provides
multiple EBPs and links individuals at their most vulnerable point to community resources will
assist in decreasing the "stacking" of behavioral health problems in emergency rooms and ease
access to emergency care for truly emergent patients.

Quality:

To achieve continuous quality improvement we shall assess the projects impact and make
adjustments as necessary using a PDSA approach. We will share best practice and lessons
learned, seize scaling opportunities to expand successful outcomes to broader populations, and
rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and
patient centered care, in the most cost effective way, improves the health care infrastructure to
better serve the Medicaid and uninsured residents of the counties we serve, further develops and
maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

Prior to 2012 no services of this type were available. Zero encounters were being made and zero
physicians, physician assistants, advance practice nurses, or social worker, psychology or case
coordination trainees were receiving training in EBPs for SMI at this location. At the University
Hospital, readmissions within 30 days for the same quarter in the year before the opening of the
TCC were 54 out of every 1000. Readmissions within 72 hours were 37 per 1000.

Rationale:

A program that is adaptable, aligned with patient needs and provides wrap around service and
EBPs within their community offers a unique opportunity to continually adapt practices to
improve health in a vulnerable and difficult to treat population. The project will allow expansion
of the TCC to serve greater numbers of patients in need. An issue identified in the 2010 Bexar
County Community Health Assessment, as well as every other assessment over the past 2
decades is the lack of mental health care workers and services for individuals in crisis. Creating
an inter-professional training clinic has the added advantage of addressing the severe shortage of mental health providers in the area. Trainees exposed to our rapid PDSA cycle learn to be more agile in responding to patient and community needs and are more likely to translate what they have learned to other work settings with similar populations, thereby addressing potential behavioral issues early on before they reach crisis proportions. Patients served, individuals trained and PPAs are clear, objective methods to measure the outcome. This project is already funded in a limited fashion through a Methodist Healthcare Ministries grant. Early experiences have allowed us to define new challenges and to better target this request to meet those challenges. In particular, issues of transportation, providing medication for indigent patients, creating a living data base of community resources, providing short term EBPs and ensuring linkage to community resources will be addressed.

Our community has defined crowding of emergency rooms by people seeking behavioral health treatment to be a major issue. Use of a scarce resource not only increases wait time for all patients, but also adversely effects patients with urgent medical needs that need emergency treatment. Deflecting access to care issues from emergency centers to a transitional program and decreasing readmissions to EDs due to inability to provide follow up care will directly impact this issue of “stacking” and address a major community concern.

At this time, the Local Mental Health Authority offers a wrap-around service to patients who present to their Crisis Care Clinic. That program has diverted these individuals from the emergency room. However, the CCC does not impact those who already use the emergency room as their access point to health care. In addition, patients utilizing CCC continue to utilize (and be referred by the CCC to) the emergency department whenever substance use or co-morbid medical conditions are involved. Currently there is no care coordination between the Emergency Department and referrals.

CN.1 Enhance quality by delivering care in the right setting
CN.4 Provide mental health services to at risk populations

**Related Category 3 Outcome Measure(s):**

Rehospitalization- Hospitalization is the single most costly intervention for individuals with behavioral health diagnoses and preventing readmission and ED diversions is a primary goal of the community. The TCC will achieve this goal by providing rapid access to care and multiple EBPs including medication management, Cognitive Adaptation Training, Cognitive Behavior Therapy, and Case coordination. Focusing on PPAs will allow rapid and evidence-based treatment in the community where individuals have maximal independence and costs of care are lower.

**Relationship to other Projects:**

This project will directly reinforce others that aim to support holistic patient care within the community. Other projects being submitted from our department will create a substance use disorder clinic and training program that will specifically address co-morbid substance use and mental health. Together, addressing these issues in the period of increased vulnerability a person experiences post hospitalization or post crisis, these projects will have a direct impact on recurrent hospitalization and emergency room visits leading to a decrease in the crowding and "stacking" of behavioral health patients in emergency departments.
Relationship to Other Performing Providers’ Projects in the RHP:

This project will directly reinforce others that aim to support holistic patient care and wellness within the community. Several other projects in the region plan to establish post-discharge support for behavioral health/substance abuse as well as developing innovation for provider training and capacity. These providers include the Center for Health Care Services and University Health System. The current project builds on a pre-existing grant that has already begun to realize both of those goals. As these providers already have a relationship, this would be an ideal nidus for a Learning Community to share what we have already learned and translate it to other areas of the RHP that have not submitted similar projects. Other projects being submitted from our department will create a substance use disorder clinic and training program that will specifically address the complicated issues of mental illness with co-morbid substance use. Together, addressing these issues in the period of increased vulnerability a person experiences post hospitalization or post crisis, these projects will have a direct impact on recurrent hospitalization and emergency room visits leading to a decrease in the crowding and "stacking" of behavioral health patients in emergency departments.

Plan for Learning Collaborative:

Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which will identify participants, establish Learning Collaborative goals, develop a calendar of meetings, visits and or calls, develop a plan to communicate ideas, data and successes across the region and state, adopt metrics to measure success and may organize a learning event to share knowledge and best practices. We anticipate playing a large role in such a community as we have already faced some of the challenges related to connecting with and supporting individuals after a behavioral health crisis and ED or hospital visit.

Project Valuation:

Within the 5 years of this project, we will 1) deliver wrap-around services to at least 3600 individuals in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual prior to ensure connection with longer-term services in the community 2) develop, deploy and maintain a web-based system to be used by all referring hospitals and emergency departments. We expect 80% of all referrals to be web based, with an estimated 35 patients referred daily by the end of the waiver period. 3) Train over 40 providers in application EBPs for the seriously mentally ill using an inter-professional treatment model that is easily replicable throughout Texas. This project will not only impact access to care within Bexar County, but will train 10 providers yearly in an evidence based inter professional treatment model that is easily replicable throughout Texas. As described above, lack of knowledge of community programs and economic factors combine to foster use of high level services in emergency departments, particularly among those without access to general health care. Patients with severe mental illness who are seen and dismissed from emergency departments often lack ability to connect to social supports revisit the emergency department whenever a perceived need arises. Furthermore, care coordination after hospitalization is generally insufficient to ensure connection to community supports. Over the period of the waiver, at least 40 new providers will be trained to ensure that these needs are met in the community in a timely fashion to prevent emergency department visits. They, in turn can replicate this program in communities all over the region and the state.

An estimated 35 patients daily will ultimately be referred via the web based referral system
by the end of the waiver period. This immediate referral and initiation of care coordination to over 3600 patients will decrease re-hospitalization within 1 year for behavioral health issues by two-thirds over 4 years which not only represents a major cost savings, but also an increase in access to scarce hospital beds. Similarly, immediate referral will have a major impact on 72 hour behavioral health readmission to the emergency department.

Combined increase in capacity and rapidity of access to care after a crisis or hospitalization decompresses hospital and emergency services and spawns a shift from high acuity, expensive care to community based prevention and care. Re-hospitalization and emergency room revisit rates from Major Hinchman 2010 study yield the cost lack of care coordination between inpatient/ED and outpatient settings as well as of the delay in accessing care. This was coupled with the anticipated cost of developing and maintaining a web-based tool.

**Milestone 1,4,7,11:** Each new prescribing psychiatric APN and PA entering the community to provide services yearly will increase capacity by approximately 350 patients/caseload. This creates a decrease on the crisis and emergency services as well as decompressing the caseloads in primary care. Social workers and LPCs trained in EBP case-management practices for the seriously mentally ill will increase the availability of localized community based behavioral health services. This is the most difficult milestone to value as a many of these services are prevention based in agencies that are not strictly mental health, but work with families and youth. **Milestone 2,5,8, 12:** Re-hospitalization and emergency room revisit rates from Major Hinchman 2010 study yield the cost lack of care coordination between inpatient/ED and outpatient settings as well as of the delay in accessing care. This was coupled with the anticipated cost of developing and maintaining a web-based tool. **Milestone 3,6,9,13:** Valuation is estimated using the 2011 Community Assessment percentage of individuals in Bexar County who do not have a usual source of care and are presumed to visit crisis clinics or emergency rooms for behavioral healthcare needs including detox and other substance related issues and domestic crises. Improvement Milestone 10,14: Valuation is estimated based upon costs of a typical psychiatric admission ($8100) per stay.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>085144601.3.20 3.1.T-3.8</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Behavioral Health/Substance Abuse 30 day readmission rate</td>
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</table>

**Milestone 1**

**[P-2]: [Design (and implement) specialized community interventions for target populations]**

**Metric 1 [P-2.1]: [Train 8 social work, psychology or case management trainees, 1 advanced-practice nurse and 1 physician's assistant in application of Evidence Based Practices (EBPs) for SMI. Our Department is an internationally recognized leader in EBP treatment for SMI.]**

**Baseline/Goal:** [baseline 0/ goal of increasing by 800%]

**Data Source:** Training and supervision records

**Milestone 1 Estimated Incentive Payment:** $678,000

**Milestone 4**

**[P-2]: [Design (and implement) specialized community interventions for target populations]**

**Metric 1 [P-2.1]: [Train 8 NEW social work, psychology or case management trainees, 1 advanced-practice nurse and 1 physician's assistant in application of Evidence Based Practices (EBPs) for SMI. Our Department is an internationally recognized leader in EBP treatment for SMI.]**

**Baseline/Goal:** [baseline 0/ goal of increasing by 1600%]

**Data Source:** Training and supervision records

**Milestone 4 Estimated Incentive Payment:** $744,528

**Milestone 7**

**[P-2]: [Design (and implement) specialized community interventions for target populations]**

**Metric 1 [P-2.1]: [Train 8 NEW social work, psychology or case management trainees, 1 advanced-practice nurse and 1 physician's assistant in application of Evidence Based Practices (EBPs) for SMI. Our Department is an internationally recognized leader in EBP treatment for SMI.]**

**Baseline/Goal:** [baseline 0/ goal of increasing by 2400%]

**Data Source:** Training and supervision records

**Milestone 7 Estimated Incentive Payment:** $597,354

**Milestone 11**

**[P-2]: [Design (and implement) specialized community interventions for target populations]**

**Metric 1 [P-2.1]: [Train 8 NEW social work, psychology or case management trainees, 1 advanced-practice nurse and 1 physician's assistant in application of Evidence Based Practices (EBPs) for SMI. Our Department is an internationally recognized leader in EBP treatment for SMI.]**

**Baseline/Goal:** [baseline 0/ goal of increasing by 3200%]

**Data Source:** Training and supervision records

**Milestone 11 Estimated Incentive Payment:** $577,154
<table>
<thead>
<tr>
<th>Milestone 2</th>
<th>Milestone 5</th>
<th>Milestone 8</th>
<th>Milestone 12</th>
</tr>
</thead>
</table>
| **[P-X. ]:** Deploy and maintain a web-based referral system  
**Metric 1** [P-X.1]: Percent of TCC referrals from hospitals and emergency departments made via web  
Baseline/Goal: 0/50%  
Data Source: | **[P-X. ]:** Maintain a web-based referral system  
**Metric 1** [P-X.1]: Percent of TCC referrals from hospitals and emergency departments made via web  
Baseline/Goal: 0/60%  
Data Source: | **[P-X. ]:** Maintain a web-based referral system  
**Metric 1** [P-X.1]: Percent of TCC referrals from hospitals and emergency departments made via web  
Baseline/Goal: 0/70%  
Data Source: | **[P-X. ]:** Maintain a web-based referral system  
**Metric 1** [P-X.1]: Percent of TCC referrals from hospitals and emergency departments made via web  
Baseline/Goal: 0/80%  
Data Source: |
| Milestone 2 Estimated Incentive Payment: $678,000 | Milestone 5 Estimated Incentive Payment: $744,528 | Milestone 8 Estimated Incentive Payment: $597,354 | Milestone 12 Estimated Incentive Payment: $577,154 |

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<thead>
<tr>
<th>Milestone 3</th>
<th>Milestone 6</th>
<th>Milestone 9</th>
<th>Milestone 13</th>
</tr>
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</table>
| **[P-3.1]:** Serve individuals with complex target needs: Deliver wrap-around services in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual  
**Metric 1** [P-3.1]:  
Baseline/Goal: 0/600 individuals  
Data Source: Medical record | **[P-3.1]:** Serve individuals with complex target needs: Deliver wrap-around services in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual  
**Metric 1** [P-3.1]:  
Baseline/Goal: 0/800 individuals  
Data Source: Medical record | **[P-3.1]:** Serve individuals with complex target needs: Deliver wrap-around services in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual  
**Metric 1** [P-3.1]:  
Baseline/Goal: 0/1000 individuals  
Data Source: Medical record | **[P-3.1]:** Serve individuals with complex target needs: Deliver wrap-around services in the immediate post-discharge/diversion period with average number of wrap around visits=4 per individual  
**Metric 1** [P-3.1]:  
Baseline/Goal: 0/1200 individuals  
Data Source: Medical record |
| Milestone 3 Estimated Incentive Payment: $678,000 | Milestone 7 Estimated Incentive Payment: $744,528 | Milestone 9 Estimated Incentive Payment: $597,354 | Milestone 13 Estimated Incentive Payment: $577,154 |

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<thead>
<tr>
<th>Milestone 10</th>
<th>Milestone 14</th>
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<tbody>
<tr>
<td><strong>[I-X]:</strong> Reduce 30 day potentially preventable readmission rates by 10% from</td>
<td><strong>[I-X]:</strong> Reduce 30 day potentially preventable readmission rates by 15% from</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone</td>
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<td>---------------------------</td>
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</tr>
<tr>
<td>Bundle Amount: $2,034,001</td>
<td>Bundle Amount: $2,233,585</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,965,617**
Identifying Project and Provider Information:
Title: 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic disease: Expanding chronic care management in a safety net clinic
Unique RHP ID#: 085144601.2.4 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Project Summary:

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. UTHSCSA clinics serve a large number of Medicaid and uninsured patients. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): The project will implement specific Chronic Care Model activities within the practice, including a comprehensive care management plan, adopting evidence-based protocols, implementing patient self-management plans for chronic conditions, nurse-care management and medical group visits.

Need for the project: The practice’s patient population has high levels of poorly controlled chronic diseases, including diabetes mellitus, hypertension, and others. Barriers to better performance include a patient population with severe socioeconomic disadvantage needing more support, combined with a delivery system that has not yet implemented a comprehensive care management plan for these patients. The Chronic Care Model is an evidence based mechanism for organizing effective care and improving outcomes.

Target population: The practice serves a largely Latino disadvantaged urban population, 50% of whom are uninsured patients receiving care through a county assistance plan, 15% on Medicaid, and 4% self pay. Chronic disease prevalence is high and control poor; for example diabetes prevalence in the patient panel is 35%, with 1 in 4 of those having glycosylated hemoglobin values greater than 9%.

Category 1 or 2 expected patient benefits: The project seeks to enroll 50 patients in medical group visits in Year 3, 75 in year 4 and 100 in Year 5. For the self-management plan, we expect to enroll 75 in Year 3, 150 in Year 4 and 250 in Year 5. For the care model and protocols, we plan to have 200 patients receive care under the model in Year 3, 400 in Year 4 and 600 in Year 5.

Category 3 outcomes: IT 1.10 The project seeks to reduce the proportion of adult patients with diabetes who have glycosylated hemoglobin >9%. Starting at a baseline of 25%, the goal is to reach 22.5% in Year 4 and 17.5% in Year 5.

Project Description:
The project goal is to implement patient management consistent with the Chronic Care Model (CCM) in a large safety net primary care practice. The practice serves a vulnerable patient population with high burdens of chronic disease and socioeconomic disadvantage. Although the practice has made recent progress in reconfiguring its systems (see below under “baseline”)

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limited resources have prevented the hiring of sufficient personnel with the right training to more fully implement elements of the CCM. Specifically, there has been a need for nurse care managers, medical assistants in numbers sufficient to allow for registry activities or delegation of standing orders, and community health workers (CHW) to help patients navigate the system and activate community health workers. As a result, patients do not have access to nurse care management, medical assistants remain fixed in traditional roles taking vital signs and rooming patients, and a small CHW pilot was just completed (the CHW component is described in a related project 2.9.2). But the practice still lacks evidence-based protocols for most chronic disease management (opioid management is an exception), does not assess its performance on population-based process or outcome metrics for outpatient care, and has little internal capacity for patient self-management support.

This project will address those challenges through a systematic process from comprehensive care planning, through hiring and training of necessary personnel, to implementation of specific CCM activities. The specific plans are as follows:

A practice improvement team with representation from practice leadership, physicians, mid-level practitioners, nurses, medical assistants, and front office will meet weekly to plan a comprehensive care management program. “Comprehensive” means considering all domains of the CCM including health system, delivery system design, information systems, decision support, patient self-management support, and mobilizing community resources. CCM training for new and existing staff will be developed from resources made available by the Robert Wood Johnson Foundation, the American Academy of Family Physicians, TEAMcare, Agency for Healthcare Research and Quality, and other sources.

A critical component of the project is the use of health system utilization and EHR data to identify patients for coordinated care management. This proactive risk assessment will focus resources on identifying patients with clinical parameters for hypertension and diabetes that are above recommended therapeutic goals, as well as patients with poor follow-up histories. Effort will be devoted in the first 2 project years to developing and testing these queries and reports.

To focus the team’s activities, members of the improvement team will develop evidence-based clinical protocols for the 2 most common DSRIP Category 3 diagnoses of chronic disease in our practice: type 2 diabetes mellitus and hypertension. The protocols will consider best practices for clinician management, disseminating guidelines, patient engagement, tracking outcomes, protocols for self-management support by a nurse care manager, care coordination, and connecting with community resources.

A self-management program based on the work of Lorig (Ann Beh Med 2003;26:1) and others will be created from available resources, with special attention to approaches appropriate for our patients’ culture and health literacy (Lorig et al, Nurs Res 2003;52:361). In addition, we will conduct group medical visits. Our implementation of this concept will assemble high-risk patients (identified by no or inconsistent visits for chronic care, poor control of diabetes or hypertension, sentinel health events such as hospitalization or ER visits for the two conditions, or nomination by clinicians) for structured interactions with a team including physicians, nurses, care-manager, pharmacist, social worker, and community health worker. Multidisciplinary assessment in this setting allows the team to efficiently evaluate patients’ needs while
coordinating efforts across disciplines.

Additional personnel to be hired for this project include:
Year 1 – Nurse Care Manager
Year 2 – 1 additional Nurse Care Manager; 3 additional Medical Assistants
Year 3 – 1 additional Medical Assistant

We will address all 5 required core project components under Project 2.2.1:
a) We will design and implement care teams that are tailored to the patient’s health care needs, including non-physician health professionals, such as pharmacists doing medication care managers providing care outside of the clinic setting via phone, email, and home visits; and navigators (in the linked project) helping patients successfully engage with the health care system.
b) Ensure that patients can access their care teams in person or by phone or email. We are now tracking appointment access time and have developed protocols for telephone access and monitoring of call line performance.
c) Increase patient engagement. The project addresses patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.
d) Through self-management education by the nurse care manager (and community health workers in the linked project) we will create mechanisms to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.
e) Quality improvement for project is built in with specific performance goals specifying methods such as rapid cycle improvement.

The expected major 5-year outcome for this project is improved care processes for diabetes, better disease control, and improved health outcomes, measured by reductions in patients with uncontrolled hyperglycemia (HbA1c >9%).

Region 6 RHP Goal:
To achieve continuous quality improvement we shall assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Quality:
This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.
Starting Point/Baseline:

Our Family Health Center clinic cares for approximately 17,000 unduplicated patients (2010-11 data) over a two-year period, the majority (75%) of which are enrolled in Bexar County's CareLink program for uninsured residents or Medicaid/dual eligible. In the past 5 years, the FHC has successfully implemented a number of practice improvements, including open access for children and improved access for adults; improvements in telephone and refill systems, and small CCM pilots under HRSA training grants. An important initial condition for project success is that senior management is heavily committed to and engaged in practice improvement. The department Chair, the Vice Chair for Clinical Services, and the practice Medical Director actively participate on the improvement team.

However, limited resources have prevented the hiring of sufficient personnel with the right training to more fully implement elements of the CCM. Specifically, there has been a need for nurse care managers, medical assistants in numbers sufficient to allow for registry activities or delegation of standing orders, and community health workers (CHW) to help patients navigate the system and activate community health workers. As a result, patients do not have access to nurse care management, medical assistants remain fixed in traditional roles taking vital signs and rooming patients, and a small CHW pilot was just completed (the CHW component is described in a related project). But the practice still lacks evidence-based protocols for most chronic disease management (opioid management is an exception), does not assess its performance on population-based process or outcome metrics for outpatient care, and has little internal capacity for patient self-management support.

Our baseline for glycosylated hemoglobin (HbA1c) values >9% for patients with at least one measurement in the calendar year is 25%.

Rationale:

As noted in the 2010 Community Health Assessment, Bexar County, and especially its poor and underserved minority residents, face high rates of common chronic diseases such as diabetes, hypertension, cardiovascular disease, obesity, and cancer. Specifically, Bexar County, TX had a diabetes prevalence among adults >18 y/o of 13.5% in 2006-07; the median among other communities sampled by the Behavioral Risk Factor Surveillance System was 7.6% (MMWR Surveillance Summaries September 24, 2010 / 59(SS08):1-37). In that same dataset the proportion of Bexar County respondents with diabetes mellitus who reported at least 2 glycosylated hemoglobin measurements in the past year was 65.5% vs. 66.3% as the nationwide median. For hypertension, the Bexar County adult prevalence in 2007 was 28.1% with a U.S. county median of 27.4% (MMWR Surveillance Summaries February 5, 2010 / Vol. 59 / No. SS-1). Providing effective chronic care management to this population will improve the quality and effectiveness of care, leading to reductions in preventable morbidity and mortality.

This project specifically addresses the “poor health care quality” and “high rates of chronic disease” indicators listed in the community needs document.

The rationale for our overall approach using the CCM as a guide is supported by ample evidence that the CCM is an effective framework for primary care interventions (Bodenheimer et al, JAMA 2002 Pt.2). Yet outcome improvements do not necessarily follow process improvements based on the CCM (Chin et al, Diabetes Care 2004; Landon et al, NEJM 2007). Several analyses
of the reason for this dissociation have concluded that successful interventions are more likely to have addressed multiple CCM domains, in particular both professional performance and its organizational context (Renders et al, Diabetes Care 2001; Coleman et al Health Affairs 2009). Therefore in this project we seek to significantly alter the organizational context, aiming for a system centered on multidisciplinary collaboration and proactive population management.

The rationale for selecting the milestones began with the premise that comprehensive care management planning was necessary to address all aspects of the chronic care model in a setting where such comprehensive assessment has never occurred. We will accomplish this through carefully planning a CCM approach at the project’s start, using a collaborative, inclusive process that involves all job titles in our center. The working plan will specify new roles, collaborations, and team-based accountability for process and improvement milestones. This initial work is essential to achieving the critical CCM component of health care organization that is built on a foundation of leadership and staff engagement (Bodenheimer et al, JAMA 2002 Pt.1). Delivery system design is addressed through reducing reliance on physicians for certain tasks such as standing orders in prevention/chronic disease management – these will be assumed by MA’s – while adding new roles such as nurse care managers and community health workers who can assist with supporting patient self-management and linkage to community resources and partners. Decision support will be built in by creating evidence-based protocols for stepped management of diabetes and hypertension, while information systems will provide essential feedback on performance.

The process milestones below were selected to create a logical flow from planning, to developing an overall CCM approach, to developing specific elements supporting the CCM Hroscikoski et al, Ann Fam Med 2006;4:317). The Category 2 milestones focus on program development, staff training, and ongoing improvement, while specifying the number of patients who will receive care under the different CCM components.

We are not aware of any projects at UTHSCSA funded by the U.S. Dept. of Health and Human Services that serve a similar purpose to this proposed project.

CN. 2 Project meets need for improved management of patients with chronic conditions

Related Category 3 Outcome Measure(s):

The selected Category 3 outcome milestones address process and improvement milestones. The process milestones set specific goals for planning, testing data systems, and establishing baseline rates that will support the improvement milestones.

We specify two improvement milestones:

IT 1.10 HbA1c poor control (>9%). We chose this milestone because our system-wide assessments reveal that the prevalence of poor diabetes control is high in our population. For example, in the year from mid-2010 to mid-2011, 4,867 of 17,705 patients (27.5%) with a measured HbA1c had values over 9%. The proportion for patients having more than one reading
was 24.5%. Also, there are persistent disparities in control of diabetes by socioeconomic status and race/ethnicity (McWilliams et al, Ann Int Med 2009;150:505) that require special attention to the needs of vulnerable populations.

Relationship to other Projects:
This project relates to “Community health worker program to address health and social needs in a vulnerable population.” (Unique RHP ID#:08514460-2.9.2). The projects are mutually supportive. The proactive assessment of the patient panel employed in this project will identify high-morbidity patients likely to benefit from health system navigation and enhanced connections to community resources.

Relationship to Other Performing Providers’ Projects in the RHP:
Other providers and projects with the same project area:
CHOSA – 2.2 - Asthma Program.
University Health System – 2.2 – Expand chronic care models.

Plan for Learning Collaborative:
Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:
- Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaboratives to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.

Project Valuation:
Achieves waiver goals: The project directly addresses waiver goals, with its Triple Aim objectives, improvement of health care infrastructure at a safety net clinic where more than 75% of patients are uninsured or on Medicaid. The CCM approach will created a coordinated care system that is consistent with other models for which there is strong evidence of improved outcomes while reducing costs 10-30% (Nielsen, PCPCC 2012; Grumbach, PCPCC 2010).

Addresses community needs: The project directly addresses the high prevalence of poorly controlled diabetes and other chronic diseases in the community. Impact on better disease control should be significant, [Nielsen:2012wt] though public health approaches are necessary to reduce
incidence of common chronic diseases.

Project Scope – the project is implemented in a safety net clinic with 17,000 unduplicated patients seen over a two-year period. The panel has a high prevalence of diabetes with many patients not meeting standards for control.

Project Investment - The expected investment in human resources and time to implement is relatively small. Capital investments are minimal. Gaining experience with implementations of the chronic care model and population management in primary care is important for University Health System in the era of Accountable Care Organizations.
<table>
<thead>
<tr>
<th>085144601.2.4 PASS 1</th>
<th>2.2.1</th>
<th>2.2.1 A-E</th>
<th>2.2.1 REDISEIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES</th>
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<td>University of Texas Health Science Center at San Antonio</td>
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<td>Related Category 3 Outcome Measure(s):</td>
<td>085144601.3.21</td>
<td>3.IT-1.10</td>
<td>Diabetes care: HbA1c poor control (&gt;9.0%)</td>
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<th>Year 2</th>
<th>Year 3</th>
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**Milestone 1**
P-3 – Develop a comprehensive care management program
**Metric 1:** Documentation of a care management program based on Wagner's Chronic Care Model
Baseline/Goal: Baseline of no plan documented to goal of approved care management plan
Data Source: Program Materials including approved care management plan
Rationale: Evidence reviews demonstrate CCM can effectively guide primary care improvement.

Milestone 3 Estimated Incentive Payment: $711,900.50

**Milestone 2**
P-11 Develop and implement a program to help patients better self-manage their chronic conditions.
**Metric 1:** Increase the number of patients enrolled in the SMP to 75 from zero.
Baseline/Goal: 0/75.
Data Source: Program records
Rationale: Lorig’s self-management program is an evidence-based approach to improving self-care behaviors.

Milestone 3 Estimated Incentive Payment: $390,877.25

**Milestone 3**
P-11 Develop and implement a program to help patients better self-manage their chronic conditions.
**Metric 1:** Increase the number of patients enrolled in the SMP to 150 from 75.
Baseline/Goal: 75/150.
Data Source: Program records

Milestone 7 Estimated Incentive Payment: $418,147.75

**Milestone 4**
P-10 Expand and document interaction types between patient and health care team

**Milestone 5**
P-10 Expand and document interaction types between patient and health care team beyond one-to-one visits
**Metric 1:** Number of patients enrolled in group visits.

Milestone 8 Estimated Incentive Payment: $404,007.50

**Milestone 6**
P-11 Develop and implement a program to help patients better self-manage their chronic conditions.
**Metric 1:** Increase the number of patients enrolled in the SMP to 250 from 150.
Baseline/Goal: 150/250.
Data Source: Program records

Milestone 11 Estimated Incentive Payment: $404,007.50

**Milestone 7**
P-10 Expand and document interaction types between patient and health care team beyond one-to-one visits
**Metric 1:** Number of patients enrolled in group visits.

Milestone 12 Estimated Incentive Payment: $404,007.50
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<tr>
<th>Milestone</th>
<th>Incentive Payment</th>
<th>Description</th>
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<tbody>
<tr>
<td>P-2 Train staff in the Chronic Care Model, including essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1: Number of patients enrolled in group visits. <strong>Baseline/Goal:</strong> 0/50 <strong>Data Source:</strong> EHR records. <strong>Rationale:</strong> Group visits help develop self-management skills through peer interaction and professional support. <strong>Milestone 2 Estimated Incentive Payment:</strong> $711,900.50</td>
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<td>Metric 2: Documentation of staff training in the CCM. Numerator: number of appropriate staff trained/Denominator: number of eligible staff. <strong>Data Source:</strong> Training records. <strong>Baseline:</strong> 0% <strong>Goal:</strong> 80% <strong>Rationale:</strong> Professional development is necessary for successful implementation of the CCM. <strong>Milestone 4 Estimated Incentive Payment:</strong> $390,877.25</td>
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<td>Milestone 5</td>
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<td>I-17 Apply the care model to targeted locally prevalent chronic diseases <strong>Metric:</strong> 200 patients receive care under the model <strong>Baseline:</strong> 0 patients <strong>Goal:</strong> 200 patients <strong>Source:</strong> EHR records <strong>Milestone 5 Estimated Incentive Payment:</strong> $390,877.25</td>
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<td>Milestone 6</td>
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<td>P-15 Meet monthly to review 50/75: <strong>Data Source:</strong> EHR records. <strong>Milestone 8 Estimated Incentive Payment:</strong> $418,147.75</td>
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<td>Milestone 7</td>
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<td>beyond one-to-one visits Metric 1: Number of patients enrolled in group visits. <strong>Baseline/Goal:</strong> 0/50 <strong>Data Source:</strong> EHR records. <strong>Rationale:</strong> Group visits help develop self-management skills through peer interaction and professional support. <strong>Milestone 4 Estimated Incentive Payment:</strong> $390,877.25</td>
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<td>Milestone 8</td>
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<td><strong>Milestone 9</strong> I-17 Apply the care model to targeted locally prevalent chronic diseases <strong>Metric:</strong> 400 patients receive care under the model <strong>Source:</strong> EHR records <strong>Milestone 9 Estimated Incentive Payment:</strong> $418,147.75</td>
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<td>Milestone 9</td>
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<td>P-15 Meet monthly to review project data and respond to it with tests of new ideas, tools, or solutions. <strong>Metric:</strong> Number of new ideas, tools or solutions tested. <strong>Data source:</strong> Records of practice improvement meetings, summarized quarterly. <strong>Milestone 10 Estimated Incentive Payment:</strong> $418,147.75</td>
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<td>Milestone 10</td>
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<td>beyond one-to-one visits Metric 2: Documentation of staff training in the CCM. Numerator: number of appropriate staff trained/Denominator: number of eligible staff. <strong>Data Source:</strong> Training records. <strong>Baseline:</strong> 0% <strong>Goal:</strong> 80% <strong>Rationale:</strong> Professional development is necessary for successful implementation of the CCM. <strong>Milestone 2 Estimated Incentive Payment:</strong> $711,900.50</td>
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<td>I-17 Apply the care model to targeted locally prevalent chronic diseases <strong>Metric:</strong> 600 patients receive care under the model <strong>Source:</strong> EHR records <strong>Milestone 13 Estimated Incentive Payment:</strong> $404,007.50</td>
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<td>Milestone 12</td>
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<td>P-15 Meet monthly to review project data and respond to it with tests of new ideas, tools, or solutions. <strong>Metric:</strong> Number of new ideas, tools or solutions tested. <strong>Data source:</strong> Records of practice improvement meetings, summarized quarterly. <strong>Milestone 14 Estimated Incentive Payment:</strong> $404,007.50</td>
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<td>Milestone 13</td>
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<td>I-17 Apply the care model to targeted locally prevalent chronic diseases <strong>Metric:</strong> 600 patients receive care under the model <strong>Source:</strong> EHR records <strong>Milestone 13 Estimated Incentive Payment:</strong> $404,007.50</td>
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<td>Milestone 14</td>
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<td>I-17 Apply the care model to targeted locally prevalent chronic diseases <strong>Metric:</strong> 600 patients receive care under the model <strong>Source:</strong> EHR records <strong>Milestone 13 Estimated Incentive Payment:</strong> $404,007.50</td>
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<td>Milestone 15</td>
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<td>P-15 Meet monthly to review project data and respond to it with tests of new ideas, tools, or solutions. <strong>Metric:</strong> Number of new ideas, tools or solutions tested. <strong>Data source:</strong> Records of practice improvement meetings, summarized quarterly. <strong>Milestone 14 Estimated Incentive Payment:</strong> $404,007.50</td>
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<td>Estimated Milestone Bundle Amount</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,275,931
### Identifying Project and Provider Information:

| Title: | 2.9.2 Implement other evidence based project to establish a patient care navigation program in an innovative manner: Community health worker program to address health and social needs in a vulnerable population |
| Unique RHP ID#: | 085144601.2.5 – PASS 1 |
| Performing Provider: | University of Texas Health Science Center at San Antonio |
| Performing Provider TPI: | 085144601 |

### Project Summary:

**Provider Description:** The University of Texas Health Science Center at San Antonio (UTHSCSA) serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. UTHSCSA clinics serve a large number of Medicaid and uninsured patients. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** The project will implement a patient navigator program linked to a primary care safety net clinic to improve diabetes outcomes. Community health workers will engage high-risk patients, identified by glycosylated hemoglobin values greater than 9%, through home and community-based interventions to address barriers to successful interaction with the health system and self-management.

**Need for the project:** The region has a prevalence of diabetes well above the national average. The practice’s patient population has high levels of poorly controlled diabetes mellitus. Barriers to better control include patients’ difficulty navigating a complex health system, difficulty adhering to treatment because of low healthy literacy, and social stresses in the home and community that impede clinical success. Patient navigation is an evidence-based mechanism to help disadvantaged minority communities successfully engage in the health system as well as to promote health in patients’ community settings.

**Target population:** The practice serves a largely Latino disadvantaged urban population, 50% of whom are uninsured patients receiving care through a county assistance plan, 15% on Medicaid, and 4% self pay. Diabetes prevalence in the patient panel is 30%, with 1 in 4 of those having glycosylated hemoglobin values greater than 9%.

**Category 1 or 2 expected patient benefits:** The project seeks to document 120 unique patients with community health worker visits in Year 3, 360 in Year 4, and 360 in Year 5 for a cumulative total of 840 high-risk patients reached over the three years. A secondary goal is to reduce emergency room visits and hospital admissions for patients seen by the CHWs.

**Category 3 outcomes:** IT 1.10 The project seeks to reduce the proportion of adult patients with diabetes who have glycosylated hemoglobin >9%. Starting at a baseline of 25%, the goal is to reach 22.5% in Year 4 and 17.5% in Year 5.
Project Description:
The goal of this project is to implement a patient navigator program linked to a primary care safety net clinic to improve diabetes outcomes. The practice serves a vulnerable patient population with high burdens of chronic disease and socioeconomic disadvantage. In this setting, where social determinants of health create high barriers to successful patient self-management, CHWs are trusted natural helpers who enhance their community’s wellbeing by responding to problematic situations. They also understand how people make decisions in real life, and they act as brokers between health professionals and their patients. CHWs role in this project will encompass a set of the following core functions in community-based development of basic skills necessary to produce health. We have developed training and practice models for these core functions in two pilot projects, now completed, funded by our county health system (Ferrer et al, J Am Board Fam Med, 2013 in press).

a. Promoting healing relationships with the health care team, meaning that CHW will assist patients in navigating health care visits and procedures, assess patients sense-making of messages from health care providers and counsel patients on effective communication and agenda-setting for clinical visits.

b. Reinforcing clinical messages as directed by the clinical team, promoting adherence with prescribed therapies.

c. Problem solving for family, social, and economic issues that may impede clinical success.

d. RN-Care Manager and CHW will coordinate their plans in twice-monthly discussions of patients in active management. The RN-CM and CHW interaction is intended to optimize problem solving for 5 cross-cutting issues in chronic disease management: healthy lifestyles, treatment adherence, behavioral illness, literacy/health literacy, and socio-environmental factors.

e. CHWs will teach community-based health education sessions, in areas where there are concentrations of high-risk patients. We have recently begun geocoding our patient addresses to identify such concentrations.

f. CHWs will promote connections with community resources relevant to patients’ needs. In our pilot project, CHWs have been creating asset maps in their communities.

The project option selected is 2.9.2, “implement other evidence-based project to establish/expand a patient care navigation program in an innovative manner.” Our use of CHWs focuses on employing them to enhance not just access to care but also to extend the primary care team into patients’ homes and communities to improve chronic disease management for vulnerable patients.

The CHWs we will employ will have been certified as community health workers through a recognized training program. The skill level we are targeting is trained peer educators from the neighborhoods where our patient population resides.

The project plan includes hiring and training 6 FTE CHWs in year one and an additional 6 FTE in year two. We have developed training curricula and materials in our pilot project. Subsequently, the CHW services will be deployed using EHR data that identifies patients with poor diabetes control (A1c>9%). Additional triggering events will include hospitalizations and emergency room visits for diabetes, poor attendance at primary care visits for diabetes follow-up. Clinicians will also be able to make referrals to CHWs when they suspect social issues are creating important barriers to successful medical management.
CHWs will meet weekly with our project improvement team to develop systems linking them closely with other team members in our chronic care model. Based on their interactions with patients, CHWs will be able to activate nurse care managers, pharmacists, or physicians if they observe specific needs during patient home assessments. In return, those healthcare professionals will be able to request that the CHWs make specific observations of adherence to care, medication use, and self-management strategies in the home environment. These meetings will also promote QI for the CHW program, as participants create, plan, and review short-cycle tests of proposed improvements.

CHW services will be tracked through structured reports of CHW activities. To help guide their work with a patient-centered focus, CHWs will assess patients’ goals related to functional status and track their progress. They will also record specific process measures such as healthcare visits facilitated, appointments made, community resource referrals, and assistance with maintaining health care coverage.

In addition to examining CHWs’ program records, we will be tracking outcomes by examining monthly reports of glycemic control, emergency department and hospital admissions for our practice cohort.

The expected 5-year outcome is a community-based CHW project that effectively links vulnerable patients to health care while also addressing patients’ social needs in the context of family and community. These processes will lead to improved control of diabetes as measured by HbA1c levels. Improved diabetes control is expected to reduce diabetes complications, improve quality of life, and decrease health care costs.

Region 6 RHP Goal:

To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Quality:

This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system and improves outcomes while containing costs.

Starting Point/Baseline:

Our Family Health Center clinic cares for approximately 17,000 unduplicated patients (2010-11 data) over a two-year period, the majority (75%) of which are enrolled in Bexar County's CareLink program for uninsured residents or Medicaid/dual eligible.

A small pilot from 2/1/12 to 1/31/13 of community health workers visiting high-utilizing socially vulnerable patients has just ended, funded by the Bexar County Hospital district. At the time of writing, approximately 60 patients were being followed by CHWs. The pilot was targeted at high-utilizers, regardless of diagnosis, and thus differs in targeting and scope from the proposed
Our baseline for glycosylated hemoglobin (HbA1c) values >9% for patients with at least one measurement in the calendar year is 25%. At present, a report like this can be generated only as a “one-off” so we will need to develop a monthly reporting system during our first project year.

Our baseline for emergency room visits and hospitalizations among our patient cohort with diabetes and HbA1c>9% will be determined in year 1 of the project.

**Rationale:**

As noted in the 2010 Community Health Assessment, Bexar County, and especially its poor and underserved minority residents, face high rates of common chronic diseases such as diabetes, hypertension, cardiovascular disease, obesity, and cancer. Specifically, Bexar County, TX had a diabetes prevalence among adults >18 y/o of 13.5% in 2006-07; the median among other communities sampled by the Behavioral Risk Factor Surveillance System was 7.6% (MMWR Surveillance Summaries September 24, 2010 / 59(SS08);1-37). In that same dataset the proportion of respondents with diabetes mellitus who reported at least 2 glycosylated hemoglobin measurements in the past year was 65.5% vs. 66.3% as the nationwide median.

Our Category 3 improvement target and valuation is based on the following considerations: there is strong evidence that moving patients from poor to fair or good glycemic control (a) reduces diabetes complications such as coronary disease, stroke, and renal failure; (b) decreases hospitalizations, and health care costs, and (c) improves patients’ quality of life. This evidence is briefly summarized and quantified below.

In recent years, data from UKPDS and other studies have led to a reconsideration of the utility and safety of aggressive glucose targets in type 2 diabetes. Our goal in this project is therefore to reduce the prevalence of markedly abnormal glycemic control, which we define as HBA1c >9%. Ample evidence documents the micro- and macro-vascular morbidity associated with uncontrolled diabetes. For example, persons with diabetes in a community-based cohort study (Atherosclerotic Risk in Communities) in the highest HbA1c quintile (A1c>8.2%) had a 2.8 fold increased risk of coronary heart disease events (on a baseline of 14.4%) compared with those in the lowest quintile (Selvin et al, Arch Int Med 2005). In a secondary analysis of data from the HOPE study, a randomized drug trial, a 1% rise in the HbA1c level was associated with a 7% increase in the risk of cardiovascular events, a 20% increase in the risk of hospitalization for heart failure, a 12% increase in total mortality risk, and a 26% increase in risk of overt nephropathy. Risks increased nonlinearly, with steeper increases in patients in the top 2 deciles of A1c (A1c >8.9%)(Gerstein, Diabetologia 2005). An observational study from the Fallon Clinic showed poor glycemic control (A1c >10%) was associated with a high risk of hospitalization -- 31 per 100 per year, twice that of patients with fair control (A1c 8-10%). Mean adjusted hospital charges were also twice as high ($3040 vs. $1380/year; in 1998 dollars) (Menzin et al, Diabetes Care 2001). A larger follow-up study from 2010 in the same system confirmed the findings: annual costs for diabetes-related hospitalizations were $3278 with HbA1c of 7-8%, $4029 at 8-9%, $4963 at 9-10%, and $6759 when the A1c exceeded 10% (Menzin et al, J Managed Care Pharm 2010). And the Group Health Cooperative of Puget Sound, found that reductions in HbA1c from a mean of 10% were associated with annual savings of $680-950 (in 1997 dollars). (Wagner et al, JAMA 2001).
Improved glycemic control also improves quality of life. A randomized trial of intensified glycemic control (from mean HbA1c of 9.3% to 7.5%) examining patients’ functional outcomes, such as quality of life, work participation, bed-days, and restricted activity days, demonstrated substantial improvements in a wide range of QOL and activity measures (Testa, JAMA 2008).

The evidence base supporting this CHW intervention derives from a variety of CCM interventions that are being adapted for low-income populations (e.g. Epping-Jordan et al, Qual Saf Health Care 2004;13:299–305; Lorig et al, Nurs Res 2003;52:361). In many of these models, CHWs collaborate closely with nurse care managers to deliver assessment and education in the home setting when patients have barriers limiting travel to the health center.

In this project the CHW role encompasses 3 models of care defined in the Community Health Worker National Workforce Study (HRSA 2007): member of care delivery team, navigator, and organizer. These models, which the report noted were not mutually exclusive, consist of working under the direction of clinicians (physicians or nurses), helping patients navigate complex health systems, and working in communities to promote self-directed change and community development (HRSA 2007).

Providing community health worker navigation to this population will enhance patients’ connections to effective care, help identify and address obstacles to self-management in the home and community environment, and provide important feedback loops with clinicians about patients’ understanding and adherence to disease management. It will enhance the quality and effectiveness of care, leading to improvements in clinical outcomes. (Brownstein et al, J Ambul Care Mgmt 2011;34:210; Balcazar et al, Prev Chron Dis;2010;7:1; Brownstein et al, Am J Prev Med 2007;32:435; Gabbay et al, Jt Comm J on Qual Pt Safety 2011).

This project specifically addresses the “high rates of chronic disease” indicators listed in the community needs document. It also addresses disparities due to socioeconomic status.

The process milestones for CHW’s unique patients served were estimated at follows. Our CHW model calls for assessments and teaching in the patients’ homes so as to provide data on contextual influences such as neighborhood setting for diet and physical activity, or family situations that interfere with self-management. We therefore estimate each CHW will make 1 visit per ½ day or 8 visits per week (with 1 day/week for meeting with clinical team and QI activities) x 45 wks (3 weeks of training/year and 2 weeks vacation) or 360 visits per year per FTE. Conservatively estimating 6 visits per year per unique patient to allow for both assessment and self-management training, each CHW FTE will manage 60 unique patients per year. We allow for 50% capacity in the first year after hire. With 6 CHW hired in year 1 and 6 additional CHW hired in year 2, the target numbers for unique patients served in years 3/4/5 are thus 180/540/720.

The process milestones for community-based classes were based on data we developed this year showing that 6 ZIP codes around our health center contain many of our high-risk, high utilizing patients. Holding 12 classes in a year will therefore allow us to reach each of those ZIP codes twice. Expanding to 18 classes will permit outreach in an additional 3 ZIP codes.

We are not aware of any projects at UTHSCSA funded by the U.S. Dept. of Health and Human
Services that serve a similar purpose to this proposed project.

CN.2 This project meets the community need for improved management of Diabetes.

### Related Category 3 Outcome Measure(s):

We will hire and train 6 FTE promotoras in disease self-management (using the Lorig self-management curriculum in each of the first 2 project years; we have certified trainers on staff) and other elements of the chronic care model, map community assets relevant to chronic disease management.

The selected Category 3 outcome measure is IT 1.10 HbA1c poor control (>9%). We chose this measure because our system-wide assessments reveal that the prevalence of poor diabetes control is high in our population. For example, in the year from mid-2010 to mid-2011, 4,867 of 17,705 patients (27.5%) with a measured HbA1c had values over 9%. The proportion for patients having more than one reading was 24.5%. Also, there are persistent disparities in control of diabetes by socioeconomic status and race/ethnicity (McWilliams et al, Ann Int Med 2009;150:505) that require special attention to the needs of vulnerable populations. In our low-income population with poor health care access, we anticipate that improved connections through community health workers to effective care and self-management support will decrease the proportion of patients with poorly controlled diabetes (Balcazar et al, Prev Chron Dis 2009;6:1). The other rationale for this measure is that poorly controlled diabetes mellitus creates high risk for the complications (myocardial infarction, stroke, nephropathy, blindness) that account for the human suffering and high costs of this disease (Elly et al, Diab Med 2008). Please see the data reviewed in “Rationale” above for details.

The targets for IT-1.10 are as follows: The achievable change in % of patients with HbA1c >9% is determined by three factors: (a) how many practice patients have HbA1c >9%, (b) of those, how many we can reach with our program’s capacity, and (c) how many of those reached achieve HbA1c <9%. Beginning with a baseline rate of 25% of patients with diabetes having A1c > 9%, our goal is to reach 22.5% by DY4 and 17.5% by DY5. Our justification for these targets is as follows. We estimate 3600 patients with diabetes in our practice, of whom ¼ or 900 will have A1c >9%. With 540 of those patients reached in DY4 (Category 2 milestone) and a 25% success rate in reducing A1c below 9, we will reach our goal of 22.5%. With an additional 720 patients reached by CHWs (Category 2 Milestone) in DY5, and continued work with the DY4 patient cohort, we expect to reach our DY5 goal of 17.5% with A1c>9.

### Relationship to other Projects:

This project relates to “Expanding chronic care management in a safety net clinic” (Unique RHP ID#: 085144601.2.4). The projects are mutually supportive. The community health worker activities in this project will extend the clinic’s capacity to reach patients in their home and community settings, enhancing the clinical team’s understanding of contextual obstacles to clinical success. Community health workers will work closely with nurse care managers to reinforce self-management support and troubleshoot stumbling blocks.
**Relationship to Other Performing Providers’ Projects in the RHP:**

Bluebonnet Trails – 2.9 – Patient navigator for persons with chronic illness.
University Health System – 2.9 – Patient care navigation program.

**Plan for Learning Collaborative:**

Following completion of the RHP Plan, University Health System will facilitate the formation of working groups of performing providers who are pursuing similar projects. These working groups will develop their learning collaborative structure which may include the following:

- Identify participants
- Establish Learning Collaborative goals
- Develop a calendar of regular meetings, site visits, and/or conference calls
- Develop a plan to communicate ideas, data, and successes across the region and state
- Organize a learning event and invite experts and other Performing Providers from outside the region to share knowledge and best practices
- Adopt metrics to measure success

University Health System will seek to provide facilitation and administrative assistance as needed to ensure the success of these endeavors. The RHP 6 website will be available to the Learning Collaboratives to network and share ideas, challenges, and success stories with colleagues. RHP 6 hopes to make significant transformational progress on its project milestones to achieve waiver goals and share what we learn with the rest of the State.

**Project Valuation:**

Achieves waiver goals - The project directly addresses waiver goals, with its objectives to improve care access and address barriers to self-management at a safety net clinic where 75% of patients are uninsured or on Medicaid. It addresses the triple aim of improved outcomes, lower costs and improved patient experience; it provides a mechanism to reduce health disparities for a socioeconomically disadvantaged population through culturally appropriate, patient-centered approaches augmented by community-based interventions.

Addresses community needs – Better management of diabetes mellitus is an identified community health priority. The project directly addresses social and contextual influences on poorly controlled chronic diseases at the patient level, but the project also addresses community based education by using CHWs, who are accustomed to assuming this role. Embedding some project activities in community settings will not only reach out to those who have difficulty accessing clinical resources, but will also promote self-management education to a larger at-risk population.

Project Scope – The project is implemented in a safety net clinic with 17,000 unduplicated patients seen over a two-year period. The prevalence of diabetes mellitus among adults in our practice is 30%

Project Investment – Implementing this project will require additional investment in community health workers for the work described. Although they are relatively low-cost health workers, their high load of community-based work means that they can manage fewer visits than a doctor or nurse in a fixed location. In addition, because this work differs in some respects from the work that CHWs are accustomed to, additional training is required for new hires, as well as a ramp-up period as they learn to work with clinical teams.
<table>
<thead>
<tr>
<th></th>
<th>2.9.2</th>
<th>NA</th>
<th>2.9.2 - IMPLEMENT OTHER EVIDENCE BASED PROJECT TO ESTABLISH A PATIENT CARE NAVIGATION PROGRAM IN AN INNOVATIVE MANNER: Community health worker program to address health and social needs in a vulnerable population</th>
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<tr>
<td></td>
<td><strong>University of Texas Health Science Center at San Antonio</strong></td>
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<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>085144601.3.22</td>
<td>IT-1.10</td>
<td>Diabetes care: HbA1c poor control (&gt;9.0%)</td>
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<th>Milestone 11</th>
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<tr>
<td>P-2: Establish/expand a health care navigation program. <strong>Metric P-2.1:</strong> Number of people trained as patient navigators. Goal: Hire and train 6.0 FTE patient navigators with Community Health Worker certification. Data source: HR records. Rationale: CHWs provide culturally appropriate connections to the health care system in home and community settings.</td>
<td>P-2: Establish/expand a health care navigation program. <strong>Metric P-2.1:</strong> Number of people trained as patient navigators. Goal: Hire and train 6.0 additional FTE patient navigators with Community Health Worker certification. Data source: HR records.</td>
<td>P-3: Provide navigation services to targeted patients enrolled in the program. <strong>Metric P-3.1:</strong> Documentation of increased number of unique patients served. Numerator: Number of targeted patients enrolled in the program. Denominator: Total number of targeted patients identified. Baseline 120 patients enrolled. Goal: Enroll and reach 540/900 patients. Data source: Program records.</td>
<td>P-3 Provide navigation services to targeted patients enrolled in the program. <strong>Metric P-3.1:</strong> Documentation of increased number of unique patients served. Numerator: Number of targeted patients enrolled in the program. Denominator: Total number of targeted patients identified. Baseline 480 patients enrolled. Goal: Enroll and reach 720/900 patients. Data source: Program records.</td>
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<th>Milestone 9</th>
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<tr>
<td>P-3 Provide navigation services to targeted patients enrolled in the program. <strong>Metric P-3.1:</strong> Documentation of increased number of unique patients served.</td>
<td>Milestone 8 Estimated Incentive Payment: $159,294.33</td>
<td>P-4 Increase patient</td>
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<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 7</strong></td>
<td><strong>Milestone 10</strong></td>
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<tr>
<td>P-X Establishing criteria for</td>
<td>Milestone 8 Estimated Incentive Payment: $148,905.67</td>
<td>Milestone 11 Estimated Incentive Payment: $153,907.67</td>
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<th>Milestone 3</th>
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<tr>
<td>Milestone 3 Estimated Incentive Payment: $101,700</td>
<td>Milestone 8 Estimated Incentive Payment: $159,294.33</td>
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<th>Milestone 4</th>
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<tr>
<td>Milestone 4 Estimated Incentive Payment: $85,025.84</td>
<td>Milestone 9 Estimated Incentive Payment: $159,294.33</td>
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### CHW services

**Metric 1** [P-9.1: Establish specific criteria defining patient selection for inclusion in the CHW program.](#)
- **Goal:** Written documentation of criteria.
- **Data Source:** Program documents.

**Milestone 2** Estimated Incentive Payment: $101,700

### Milestone 3

**P-X** Defining a cohort of clinic patients eligible for CHW services.
- **Metric 1** P-10.1: A database of patients eligible for CHW program.
- **Data source:** Electronic program files.

**Milestone 3** Estimated Incentive Payment: $101,700

### Milestone 4

**P-X** Develop work routines for CHW collaborations with primary care teams (meeting frequency, modes of verbal and written communication, record patients served.
- **Goal:** Enroll and reach 180/900 patients
- **Data source:** Program documents.

**Milestone 4** Estimated Incentive Payment: $101,700

### Milestone 5

**P-X** Develop work routines for CHW collaborations with primary care teams (meeting frequency, modes of verbal and written communication, record patients served.
- **Goal:** Enroll and reach 180/900 patients
- **Data source:** Program documents.

**Milestone 5** Estimated Incentive Payment: $101,700

### Milestone 6

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 6** Estimated Incentive Payment: $148,905.67

### Milestone 7

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 7** Estimated Incentive Payment: $148,905.67

### Milestone 8

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 8** Estimated Incentive Payment: $148,905.67

### Milestone 9

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 9** Estimated Incentive Payment: $159,294.33

### Milestone 10

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 10** Estimated Incentive Payment: $159,294.33

### Milestone 11

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 11** Estimated Incentive Payment: $159,294.33

### Milestone 12

**P-4** Increase patient engagement through patient education and coordination with community resources.
- **Metric P-4.1:** Number of classes offered.
- **Baseline:** 0 classes.
- **Measure:** Hold 6 community-based classes in self-management targeted in communities with concentrations of high-risk patients.
- **Data source:** Program records.

**Milestone 12** Estimated Incentive Payment: $159,294.33

### Milestone 13

**I-7.** Reduce number of ED visits and avoidable hospitalizations for patients enrolled in the navigator program
- **Metric I-7.1:** ED visits and avoidable hospitalizations
- **Numerator:** Number of patients enrolled in the navigator program who have had an ED visit or an inpatient admission in the year after enrollment.
- **Denominator:** Total number of patients enrolled in the program.

**Milestone 13** Estimated Incentive Payment: $153,907.67
Metric 1: P-11.1: Written guidelines for CHW collaborations with primary care team. Data source: Program documents. Rationale: Integrating CHWs closely with the clinical team will be necessary for effective collaboration and achieving patient benefit.

Milestone 4 Estimated Incentive Payment: $101,700

Milestone 7 Estimated Incentive Payment: $148,905.67

Denominator: Total number of patients enrolled in the navigator program. Baseline: To be determined from data in year prior to project initiation. Goal: 5% relative reduction in ED and avoidable hospitalization rate for enrolled patients. Data Source: EHR, navigation program database.

Milestone 10 estimated incentive payment: $159,294.33

Milestone 13 estimated incentive payment: $153,907.67

Year 2 Estimated Milestone Bundle Amount: $406,800

Year 3 Estimated Milestone Bundle Amount: $446,717

Year 4 Estimated Milestone Bundle Amount: $477,883

Year 5 Estimated Milestone Bundle Amount: $461,723

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,793,123**
Identifying Project and Provider Information:

**Title:** 2.13.2 Implement other evidence based project to provide intervention for a targeted behavioral health population to prevent unnecessary use of services. (Transdermal Alcohol Monitoring Intervention to Reduce Drunk Driving, Lower Incarceration Costs, and Prevent Recidivism)
**Unique RHP ID#:** 085144601.2.6 – PASS 2
**Performing Provider:** University of Texas Health Science Center San Antonio
**Performing Provider TPI:** 085144601

Project Summary:

**Provider Description:** The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

**Intervention(s):** Novel treatment program designed to reduce recidivism for alcohol-related driving offenses.

**Need for the project:** Alcohol is a pervasive problem in Texas, and our state has the 2nd highest number of alcohol-related driving offenses in the nation. Locally, in Bexar County, the number of DWI arrests have risen by 33% in recent years, and it ranks 3rd in Texas (behind Dallas and Harris counties) in terms of driving fatalities. Even more concerning is the fact that it is estimated that 50-75% of convicted drunk drivers continue to drive on a suspended license, indicating that existing legal remedies themselves lack sufficient impact on this costly problem.

**Target population:** Legally indigent adults convicted of alcohol-related driving offenses.

**Category 1 or 2 expected patient benefits:** We propose treating 650 offenders in this pilot program.

**Category 3 outcome:** Decrease recidivism rates for alcohol-related driving offenses by 25% to 50% compared to probation.

Project Description:

The overall goal is to develop and implement a novel program for managing individuals charged with alcohol-related driving offenses, which will provide the judicial system with a cost-effective alternative to jail and reduce rates of recidivism among offenders. This project is designed to address the Improvement Target IT-9.1 *Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.* Legally indigent adults arrested for alcohol involved driving offenses will be offered treatment. This treatment involves a novel technology that will allow us to continuously monitor alcohol use. Information from this monitoring technology is used by clinicians to guide each individuals treatment, using contingency management and motivational interviewing to help them reduce alcohol use. A target of 650 patients was chosen because it is what our clinic can accommodate in 4 years and this is sufficient to demonstrate the efficacy and feasibility of the program. At the conclusion of this program, our intention is that this model program will be adopted across the state as a cost of...
effective means to reduce alcohol driving offenses.

Quality:
To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Region 6 goals:
This project addresses the RHP 6 goal of "improving outcomes while containing costs." Reduced recidivism in alcohol driving offenses is the improved outcome. The costs savings comes from: reduction in court costs generated by recidivism; providing an alternative to incarceration and its associated costs; and the cost associated with loss of life, injury, and property damage as a result of alcohol-related motor vehicle accidents.

Starting Point/Baseline:
We propose enrolling 650 offenders in this pilot program. This is a new intervention, no clients or providers have previously experienced this kind of intervention. At the conclusion of the 5-years this model could be adopted by drug courts state-wide.

Rationale:
The project was chosen because Texas consistently ranks at the top of US DWI fatalities and recidivism. Currently legally indigent individuals with alcohol problems do not have access to treatment and instead the state bears the cost of alcohol misuse through the legal system. This project use a novel technology to continuously monitor for alcohol consumption and information from this monitoring is used in treatment to facilitate reduction in alcohol misuse. Besides being responsive to the IT-9.1, there are several clinically significant reasons to target the legal system for treatment to reduce alcohol misuse: (1) DUI arrests are objective method for identifying individuals who are experiencing impairment from alcohol misuse and an objective method to quantify treatment success (i.e. lack of recidivism); and (2) contact with the legal system is a time when those who misuse alcohol are more likely to consider reducing their drinking.

CN.4 Meets need for high quality behavioral health services that is integrated with physical health services.

Related Category 3 Outcome Measure(s):
Data supporting RHP priority. This proposal addresses needs identified in the 2010 Community Health Assessment for Bexar County; it addresses Lifestyle Behaviors (Alcohol Consumption). Alcohol is a pervasive problem in Texas, and our state has the 2nd highest number of alcohol-related driving offenses in the nation. Current judicial approaches to curb these offenses are costly; an estimated cost to the state is $5.9 billion dollars. A full 10% of the Texas state budget is for incarceration. More locally, in Bexar County, the number of DWI arrests have risen by 33% in recent years, and it ranks 3rd in Texas (behind Dallas and Harris counties) in terms of driving fatalities. More problematic is the fact that it is estimated that 50-75% of convicted drunk drivers continue to drive on a suspended license; this fact underscores the need for treatment programs that work in conjunction with existing procedures. It has been estimated that treatment of individuals that have been convicted of alcohol and/or drug offenses...
costs only 1/4th as much as the alternative, incarceration. For every dollar spent on treatment, there is an estimated return of $8.87 to the state. These statistics, when taken together, indicate the existing legal remedies themselves lack sufficient impact on this costly problem.

**Improved Health.** Current methods for managing alcohol offenses result in a very high rate of recidivism and indigent do not have access to monitored care offered by this proposal.

**Relationship to other Projects:**
This is the only intervention study to reduce alcohol related driving offenses and recidivism.

**Relationship to Other Performing Providers’ Projects in the RHP:**
No other performing providers are proposing similar projects.

**Plan for Learning Collaborative:**
Goals of the project include dissemination of findings of a manualized system for courts to use transdermal alcohol monitoring to enhance probation management and reduce recidivism of alcohol related offenses (Goal 3 of the plan).

**Project Valuation:**
While there could be a wide range of parameters used to estimate the value of this program, if you consider only three factors, the anticipated value would be at least $6,027,270. There are several ways to calculate this value:
1- Value to the individual alcohol offender. Given the typical cost of a DWI in Texas ($19,200) and recidivism rate (27%), if our programmed reduced recidivism by 25 among a 650 participants in the program there would be a cost saving of $842,400;
2- Saving due to reduce incarceration. Given the typical daily cost of housing a prisoner ($66/day) and duration of prison sentence for a DWI (180 days for first offense) if this program reduces recidivism by 25%, the prison savings is $521,235;
3- Cost associated with preventing a single fatality related to DWI is estimated to be $3,300,000. Note, the intention of conducting this program is that it would serve as a model that could be adopted throughout the state, and as a result, the value of this program would be exponentially higher (Milestone 3).
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<tr>
<th>085144601.2.6 PASS 2</th>
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<th>2.13.2 Implement other evidence based project to provide intervention for a targeted behavioral health population to prevent unnecessary use of services. (Transdermal Alcohol Monitoring Intervention to Reduce Drunk Driving, Lower Incarceration Costs, and Prevent Recidivism)</th>
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<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td>Related Category 3 Outcome Measure(s): 085144601.3.33 3.IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
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<td>Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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<td>Milestone 3 Establish relationship with stakeholders and establish baseline rates.</td>
<td>Milestone 5 Establish relationship with stakeholders and establish baseline rates.</td>
<td>Milestone 7 Establish relationship with stakeholders and establish baseline rates.</td>
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<td>Metric 1 P-1 Goal: Work with hospital emergency departments, social workers, and courts to refine our develop and refine the treatment program to meet the needs of alcohol offenders.</td>
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<td>Metric 1 P-1 Goal: Work with hospital emergency departments, social workers, and courts to refine our develop and refine the treatment program to meet the needs of alcohol offenders.</td>
<td>Metric 1 P-1 Goal: Work with hospital emergency departments, social workers, and courts to refine our develop and refine the treatment program to meet the needs of alcohol offenders.</td>
</tr>
<tr>
<td>Metric 2 P-2, &amp; P-3 Production of a report characterizing rates of alcohol driving offenses in Bexar county and rates of recidivism for past alcohol driving convictions. Data Source: court records Texas Department of Public Safety and analyses by</td>
<td>Metric 2 P-2, &amp; P-3 Production of a report characterizing rates of alcohol driving offenses in Bexar county and rates of recidivism for past alcohol driving convictions. Data Source: court records Texas Department of Public Safety and analyses by</td>
<td>Metric 2 P-2, &amp; P-3 Production of a report characterizing rates of alcohol driving offenses in Bexar county and rates of recidivism for past alcohol driving convictions. Data Source: court records Texas Department of Public Safety and analyses by</td>
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<tr>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
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<tr>
<td>Payment: $227,088.50</td>
<td>Payment: $249,753</td>
<td>Payment: $268,126</td>
<td>Payment: $258,744</td>
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</table>

**Milestone 2**

I-X: Complete 600 visits from enrolled offenders

- **Metric 1** – P-5, P-6, P7
- Goal: Complete 600 visits from 100 offenders enrolled in the treatment.
- Data Source: court records Texas Department of Public Safety and analyses by Performing Provider

**Milestone 2 Estimated Incentive Payment:** $227,088.50

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<td><strong>Milestone 8</strong></td>
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</table>

**Milestone 4**

I-X: Complete 900 visits from enrolled offenders

- **Metric 1** – P-5, P-6, P7
- Goal: Complete 900 visits from 150 offenders enrolled in the treatment.
- Data Source: court records Texas Department of Public Safety and analyses by Performing Provider

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<td>Bundle Amount: $536,252</td>
<td>Bundle Amount: $517,489</td>
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**Year 2 Estimated Milestone Bundle Amount:** $454,177

**Year 3 Estimated Milestone Bundle Amount:** $499,507

**Year 4 Estimated Milestone Bundle Amount:** $536,252

**Year 5 Estimated Milestone Bundle Amount:** $517,489

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,007,425
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutional health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others): Patient Navigator for Persons with Chronic Mental Illnesses</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 1268443-05.2.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
</tr>
<tr>
<td>Performing Provider TPI: 126844305</td>
</tr>
</tbody>
</table>

### Project Summary:

**Provider Description:** Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. We operate services in Guadalupe County and we have responsibility to identify gaps in service or barriers to access for persons diagnosed with behavioral health disorders residing in the area.

**Intervention(s):** BTCS proposes to work in collaboration with the Guadalupe Regional Medical Center to implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders. We will employ a Peer Support Specialist and a registered Nurse to work on site at Guadalupe Regional Medical Center to provide rapid triage, assessment and alternative services to frequent users of the ED. The RN will provide patient education, assessment and guidance on follow up care. The Peer Support Specialist will identify community resources and directly link and advocate for the patients. Peer Support Specialists are former or current consumers of behavioral health services. Linkage and referral will include transportation to services by BTCS workers in currently owned transport vehicles.

**Need for the project:** This project addresses the RHP 6 Community Needs Assessment Needs:

- **CN.2** “A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions”;
- **CN.3** “Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages”; and especially **CN.4** “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services.”

**Target population:** Are target population those users of ED services who are admitted more than 5 times in one year. BTCS served 3,377 persons in Guadalupe County in FY 2012; 2,401 persons with mental illnesses. An average of 43% of the adults and 76% of the children with mental illnesses were eligible for Medicaid or CHIP and approximately 25 % of non-Medicaid adults were indigent. We expect about 75 % of the persons benefitting from these navigation services to be Medicaid or CHIP eligible or uninsured. We expect to serve 30 people in DY 4 and 50 people in DY 5.

**Category 1 or 2 expected patient benefits:** The starting point/baseline for this service in DY 2 is 0 since no such service currently exists in this County. The project seeks to serve 30 people in DY
4 and 50 people in DY 5. Those served will be high utilizers of the ED with multiple visits per year. We plan to intervene at the point of the visit and to assist the individuals in connecting for ongoing care through a medical home, thereby reducing future ED utilization.

Category 3 outcomes: IT-3.1 Our goal is to reduce all cause 30 day readmission rate for this group of high utilizers by a percentage TBD after baseline is established in DY 3.

**Project Description:**

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. We operate services in Guadalupe County and we have responsibility to identify gaps in service or barriers to access for persons diagnosed with behavioral health disorders residing in the area.

BTCS proposes to work in collaboration with the Guadalupe Regional Medical Center to implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders. We have a good relationship with this local hospital and with other health care providers in Guadalupe County. BTCS staff frequently assists the hospital with assessment, discharge and continuity of care issues for BTCS patients and therefore are familiar with key staff, facilities and resources. We continue to hold planning discussions with the leadership of Guadalupe Regional Medical Center and are hopeful that we can identify a location for the navigation program staff within the hospital itself or alternatively in the facility that BTCS is constructing in partnership with the FQHC, Community Centers of South Texas. Plans for the project are to hire an RN and a Peer Support Specialist to deliver the navigation services. The RN will provide patient education, assessment and guidance on follow up care. The Peer Support Specialist will identify community resources and directly link and advocate for the patients. Peer Support Specialists are former or current consumers of behavioral health services. They bring an ability to connect with frequent ED visitors and engage them in recovery and solutions. Using Peers is an Evidenced Based Practice promoted by the Texas Department of State Health Services (‘DSHS’) and the SAMHSA division of US Department of HHS. DSHS certifies Peer Specialists and this individual carrying out the navigation role will be certified or seek certification.

The **project goals** for the program and for the patient navigators will be to provide enhanced social support and culturally competent care to this high risk population. They will help support the patients as they seek access throughout the continuum of health care. In addition they will ensure timely, coordinated and site appropriate health care and if needed behavioral health care. The patient navigators will work closely with hospital and emergency department staff to divert non urgent patients to other more appropriate levels of care. This **project also meets regional goals to include:** integrating primary and behavioral health care; improving access for the poor and uninsured; and advancing the goals articulated in the Community Health Improvement Plan for Bexar County of 2012 to improve comprehensive behavioral health services and access for all. It also advances the triple aim of CMS because reduction in ED use by these high utilizers will have a positive impact on regional health care costs.

The **challenges** to this project are to engage those who are frequent visitors to the EDs and help
them access alternatives. This project will address this problem by providing the opportunity for a person centered intervention offered by a Peer, to connect the individuals to services at the point that they need them the most, i.e., at the point they are seeking emergency care. We expect to use community resources to fill unmet social needs such as housing, transportation, income, food and medication. For those who are in need of behavioral health services either as a short term stabilization strategy or for long-term, we will connect patients to BTCS or to primary care practitioners who can support behavioral health treatment. We plan to provide transportation to make access to healthcare as smooth as possible. BTCS currently uses staff and Peers to provide transportation in current Center owned vehicles and we plan to continue to use these personnel and resources to transport to services. This approach is aimed at resolving the multiple issues that lead to repeated visits to the ED. Our goal is to do all we can to ensure connection to aftercare and follow up rather than quick treatment and release from the ED with instructions for aftercare but no community support.

Over the next five years we expect the outcomes of this project to be the continued development robust alternatives to ED care and improve the performing provider and the healthcare system in the region. We expect the patients who receive navigation services to reduce utilization of EDs and reduce preventable readmissions as a result. These outcomes are directly achievable due to the goals and interventions described above.

**Starting Point/Baseline:**
Since this program has not been established and does not exist in Guadalupe County, the baseline for DY 2 is 0. We will use the remainder of DY 2 to identify the target population as a discrete cohort by review of emergency department admissions at Guadalupe Regional Medical Center.

**Rationale:**
The primary intent of our project, which is to establish a patient navigation program for persons with cognitive impairments who are frequent visitors to the ED. We plan to use Peer Support Specialists as navigators. These are innovative health care workers who have been consumers in the system and will bring an enhanced level of cultural competency and understanding to the process and the people who they are helping. The navigators will be assisted by RNs to act as nurse educators. The team is enriched by inclusion of a trained health care professional and Peer support, founded on recovery oriented focus ensures access to care management and education that promotes self-management. BTCS and its partner, Community Health Centers of South Texas, FQHC for Guadalupe County, are in process of building a clinic to co-locate behavioral health services with primary care services in partnership in Seguin, further enhancing access to care.

BTCS has participated as a member of the Guadalupe County Mental Health Task Force to identify behavioral health gaps and needs. Health disparity is often driven by income disparity. 11% to 20% of the population of Guadalupe County is below the poverty level. Additionally, 24% of the people in the RHP 6 region are without insurance or any third party coverage. The entire county has been designated a health care provider shortage area for behavioral health and for primary care according to US Department of HHS, HRSA. An area of concern that the hospital leadership, task force members and BTCS have identified is the repeated ED visits by a group of patients some of whom are BTCS patients and some of whom are not. Anecdotal
Evidence indicates reasons for the multiple ED visits by this group of patients, ranging from chronic behavioral health issues, mental illnesses and substance use disorders to chronic physical health issues such as asthma, chronic pain, cardiopulmonary disease, etc., but frequently triggered by behavioral health conditions. According to the Bexar County Consortium Report, the root cause of a large number of visits to the ED’s in RHP 6 is related to anxiety, symptoms of mental illness and/or substance abuse. Poverty and provider shortages coupled with cognitive deficits that are symptoms of mental illnesses, makes finding and accessing care difficult for many in Guadalupe County. We believe a special intervention provided by people who are trained in behavioral health assessment and management is required. The target population is composed of patients identified as having multiple emergency department/hospitalizations over the last year. Most of the patients have chronic health problems often exacerbated by substance abuse and mental illness. They tend to have poor compliance with treatment recommendations, often lack a medical home and have few natural community supports such as friends and family.

Since this is a wholly new program for Guadalupe County we expect to follow and carry out each of the required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

This project addresses RHP 6 Community Needs Assessment needs: CN.2 “A high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions”; CN.3 “Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages”; and especially CN.4 “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.”

BTCS has operated a free-standing mental health outpatient clinic site in Seguin in Guadalupe County for a number of years. We have been engaged in planning for a number of years with the local FQHC to build and establish a clinic site that integrates behavioral health care and primary care. This navigation project is enhanced by that delivery system reform. Our planning recently resulted in the award of a grant through the Health Resources and Services Administration Division of the US Department of HHS to develop a primary care/behavioral health care clinic site in Seguin in partnership with the Federally Qualified Health Center for Guadalupe County. These Federal funds will not be used to provide the patient navigation program, but having the integrated clinic will more effectively meet the needs of those we provide navigation services to and provide options for care and a medical home that has heretofore been unavailable.
## Related Category 3 Outcome Measure(s):

The Category 3 Outcome Measure that we selected is “OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) IT-3.1 All cause 30 day readmission rate- NQF 1789.” This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have multiple visits to EDs and we believe in many cases that has resulted in admission and readmission to hospital. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the program. Over the four years of the project we expect to dramatically reduce the number of ED visits for the target population and the associated inpatient admissions. These reductions will occur by improved chronic disease management, linkage to a primary care provider and medical home. The RN will be hired and trained to deliver culturally and linguistically appropriate services to the target population. Patients will be diverted from EDs/hospitals and linked with primary care providers who can offer a medical home. Navigators will also link patients to social support programs and behavioral health programs where a need is identified. It is expected that utilization of programs such as self-management support, patient education, improved patient provider communication and coordination with community resources will lead to increased patient engagement in maintaining their health. This outcome supports RHP 6 goals to improve health for low-income populations and link to a medical home.

## Relationship to Other Projects:

BTCS has also proposed in Category 1, Project 1268443-05.1.2. That project is the establishment of new treatment site for outpatient substance abuse care. The navigation project will be able to refer to services offered through the substance abuse clinic and thereby initiate much needed treatment and reduce returns to the ED. This is project fills a gap in services that the patient navigators will need for referral and care.

## Relationship to Other Performing Providers’ Projects in the RHP:

BTCS plans to participate in learning collaborative with Center for Health Care Services which is planning integrated care and specialized care management projects. We would also request to participate with University of Texas Health Science Center, San Antonio and University Health System both of which are planning patient navigation programs.

## Plan for Learning Collaborative:

BTCS will participate in all learning collaboratives organized or sponsored by University Health System that are relevant to our projects. As above, we will actively seek participation in other learning collaboratives in the Region. We believe it is important to improving and adjusting the care provided.
Project Valuation:
The project seeks to serve 30 people in DY 4 and 50 people in DY 5. Those served will be high utilizers of the ED with multiple visits per year. We plan to intervene at the point of the visit and to assist the individuals in connecting for ongoing care through a medical home, thereby reducing future ED utilization. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We assigned a value of $1,134,866 through DY 5. Complete write-up of project will be available at performing provider site.
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<th>1268443-05.2.1 PASS 1</th>
<th>2.9.1</th>
<th>2.9.1 A-E</th>
<th>2.9.1 PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONAL HEALTH CARE: PATIENT NAVIGATOR FOR PERSONS WITH CHRONIC MENTAL ILLNESS</th>
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<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services</td>
<td>TPI - 126844305</td>
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<td>Related Category 3 Outcome Measure(s):</td>
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<td>All cause 30 day readmission rate- NQF 1789</td>
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<td>Milestone 1</td>
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<td>Year 3</td>
<td>Year 4</td>
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<td>Milestone 1 P-1: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.</td>
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<td>Metric 1 P1.1: Provide report identifying the following:</td>
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<tr>
<td>- Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).</td>
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<td>- Gaps in services and service needs.</td>
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<td>- How program will identify, triage and manage target population</td>
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<td>Milestone 2 P-2: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.</td>
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<td>Metric 1 P2.1: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.</td>
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<td>Goal: Develop the training with procedures and continuing education. Train and deploy one RN and one Peer Support</td>
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<td>Metric 1 [I-X.1]: Number of patient in target population served by this patient navigation service.</td>
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<td>Baseline/Goal: Baseline – Baseline 0 for DY 2 since no such service currently exists in the RHP; Goal - Serve 30 people in DY4 who are high utilizers of ED services.</td>
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<td>Data Source: EHR and ED records.</td>
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<td>Milestone 5</td>
<td>Milestone 5 [I-X]: Number of patient interventions.</td>
<td>Milestone 5 [I-X.1]: Number of patient in target population served by this patient navigation service.</td>
<td>Milestone 5 Estimated Incentive Payment: $292,224</td>
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| Milestone 1 Estimated | Specialist.
Data Source: Workforce development plan for patient navigator recruitment, training and education |
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<tbody>
<tr>
<td>Milestone 2 Estimated</td>
<td>Incentive Payment: $141,363</td>
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</table>
| **Milestone 3** | **P-3:** Provide care management/navigation services to targeted patients.  
**Metric 1 P3.1:** Increase in the number or percent of targeted patients enrolled in the program  
Baseline: 0  
Goal: TBD  
Data Source: Enrollment reports |
| Milestone 3 Estimated | Incentive Payment: $141,364 |

population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).
- Ideal number of patients targeted for enrollment in the patient navigation program
- Number of Patient navigators needed to be hired
- Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients.

Goal: Produce a comprehensive report documenting all points above.
Data Source: Program documentation, EHR, claims, needs assessment Survey

Milestone 1 Estimated

Milestone 2 Estimated

Incentive Payment: $141,363

Milestone 3

P-3: Provide care management/navigation services to targeted patients.
**Metric 1 P3.1:** Increase in the number or percent of targeted patients enrolled in the program
Baseline: 0
Goal: TBD
Data Source: Enrollment reports

Milestone 3 Estimated

Incentive Payment: $141,364
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<th>Year 3 Estimated Milestone Bundle Amount: $282,727</th>
<th>Year 4 Estimated Milestone Bundle Amount: $302,452</th>
<th>Year 5 Estimated Milestone Bundle Amount: $292,224</th>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,134,866**
Identifying Project and Provider Information:

Title: 2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Transitional housing with behavioral supports
Unique RHP ID#: 1268443-05.2.2 – PASS 2
Performing Provider: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services
Performing Provider TPI: 126844305

Project Summary:

Provider Description: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 extending north of Austin, Texas in Travis County. That responsibility includes identifying gaps in service or barriers to access for persons with behavioral health issues residing in the area. We also provide behavioral health services through various contracts including a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses. BTCS is responsible for aftercare upon release from hospital and for stability in the community following ED visits, jail stays and the number disruptive of events that happen for those with SMI. Community stability cannot occur for anyone without access to housing.

Intervention(s): BTCS proposes to implement a transitional housing facility that is provided consistent with SAMHSA recognized recovery principles. We will secure, renovate, open and staff a facility suitable for about 6 individuals who will be provided behavioral health services in this transitional housing setting to improve community living skills. The program will be for individuals who have a need for housing but who are also willing to participate in a Recovery-Based Program. While in the program they will participate in psychosocial skills training to learn and practice skills to improve the likelihood of a successful transition into independent living. All admissions to the program will participate in a Wellness, Recovery, Action Plan.

Need for the project: This project addresses RHP 6 Community Needs Assessment needs CN.4 “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services.” It also addresses the lack of affordable housing in Guadalupe county for the poor and mentally ill.

Target population: The target population is our patients or potential patients referred from the Crisis Respite Unit, State Psychiatric Inpatient Facilities, and the local Community Centers. The referrals will be screened and considered based on need. We will prioritize admissions to those with long or repeated stays in inpatient settings or with frequent contacts with the criminal justice system. BTCS served 3,377 persons in Guadalupe County in FY 2012; 2,401 persons with behavioral health disorders. In FY 2012, an average of 43% of the adults were eligible for Medicaid; 73% of BTCS clients are below the federal poverty level; 55% are uninsured. We estimate that approximately 70% of those benefitting from this project will be poor, uninsured or underinsured.

Category 1 or 2 expected patient benefits: This project seeks to provide transitional housing services and placement in permanent housing for 12 people in DY 4 and 18 people in DY 5.

Category 3 outcomes: IT-3.8 Our goal is to reduce behavioral health /substance abuse 30 day
readmission rate by a percentage TBD after baseline is established in DY 3.

**Project Description:**

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Guadalupe County in Region 6 as well as for seven other Counties located east of and parallel to IH 35 extending north of Austin, Texas in Travis County. That responsibility includes identifying gaps in service or barriers to access for persons with behavioral health issues residing in the area. We also provide behavioral health services through various contracts including a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses (SMI the Federal definition can be found at “Federal Definition for SMI,” [http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc](http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc).) This group of patients generally suffers from the most profound deficits in functioning and are often unemployed, homeless or living in sub-standard housing and without natural family or community supports. Recovery is possible for these individuals but it is a difficult journey requiring help and supports. BTCS and community partners are responsible for aftercare upon release from hospital and for stability in the community following ED visits, jail stays and the number disruptive of events that happen for those with SMI. Community stability cannot occur for anyone without access to housing.

BTCS proposes to implement a transitional housing facility that is provided consistent with SAMHSA recognized recovery principles, ([National Consensus Statement on MH Recovery,](http://www.samhsa.gov/SAMHSA_News/VolumeXIV_2/article4.htm) Based on our experience providing treatment in the region and with the consensus of community leaders, we realize no housing now exists in Guadalupe County that can be used to help people make the transition to recovery. We will identify a suitable facility in Seguin, Texas to rent, remodel and use for the transitional housing project. Program participants may be referred from the Crisis Respite Unit, State Psychiatric Inpatient Facilities, and the local Community Centers. The referrals will be screened and considered based on need. The program will be for individuals who have a need for housing but who are also willing to participate in a Recovery-Based Program. While in the program they will participate in psychosocial skills training to learn and practice skills to improve the likelihood of a successful transition into independent living. All admissions to the program will participate in a Wellness, Recovery, Action Plan (WRAP) to help target the individual needs. We have identified a variety of evidenced based program models that focus on promoting recovery and self–responsibility. We will assess the models and through a process of review and evaluation, incorporate practices that enhance our current plans. (“Developing a Recovery and Wellness Based Lifestyle Guide,” [http://store.samhsa.gov/product/Developing-a-Recovery-and-Wellness-Lifestyle-A-Self-Help-Guide/SMA-3718](http://store.samhsa.gov/product/Developing-a-Recovery-and-Wellness-Lifestyle-A-Self-Help-Guide/SMA-3718); and “Consumer Operated Services – EBP,” [http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD](http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD).) The common elements in the models are that they all contain components supporting skills development, self- awareness and individual responsibility in the recovery process. For example, WRAP is listed on the SAMHSA registry of evidenced based practices. WRAP is an effective, manual-based group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. Tools and practices such as these will form the foundation of the Transitional Housing project. The program will be evaluated
quarterly and outcomes will be closely monitored. All services will be documented in our electronic information system. Data will determine the amount and frequency of the services being provided and will be utilized to help guide the program quarterly. Satisfaction surveys will be provided for individuals leaving the program to ensure we gather personal attitudes regarding the effectiveness of the program. The final phases of this program will include transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens so that individuals can smoothly move into community living.

**Goals and Relationship to Regional Goals:** Over the next five years we expect to fully implement the transitional housing program based on recovery principles. We expect the program to maintain an average census of around 6 persons who will stay from one month to six months depending on assessed need. We expect to serve 12 to 18 people each year after the program is underway. The goal of the program is to facilitate the change and recovery process for individuals with SMI through skills building, self-awareness, self-advocacy, and providing the supports necessary for stable lives in a community setting.

**Project Goals are to:**
1. Establish a Transitional Housing program based on Recovery Principles;
2. Recruit and train staff to provide transitional services;
3. Provide services to the target population of people who have been hospitalized or experienced a recent crisis event; and
4. Assist people to regain functioning and self-manage their wellness.

**This project meets the following regional goals:**
1. Further develop and maintain a coordinated care delivery system; and
2. Improve outcomes while containing cost growth.

As this program is established and grows, we expect individuals will have fewer emergency departments visits, fewer state hospitalizations, a lower rate of arrests and fewer days incarcerated. An additional benefit of this program is that it can serve as a recovery resource center to the broader community of persons in Guadalupe County with SMI who are in the process of recovery.

**Challenges:** Challenges include finding adequate housing for persons when they are ready to exit the transitional housing program to live independently or in a supportive living situation in the community. We are fortunate to have a long standing presence in the community and the support of community leaders who can assist in identifying suitable locations for independent housing. Over the next few months staff will assess houses and apartment complexes that BTCS could access. We will also work with them to find other locations in the future. Another key challenge is recruiting and training staff in recovery principles and ensuring they have the knowledge necessary to make linkages with other programs such as crisis respite and federally qualified health clinics. During DY 2 we will begin actively recruiting and review and inventory of community resources.

**5-Year Expected Outcome for Provider and Patients:** Over the next 5 years, we expect the outcomes to include reduction of readmissions to psychiatric hospitals within 30 days. The goals of this project are to establish a service that helps people improve functioning so that they can live successfully. Improvement in functioning and managing one’s wellness gives the opportunity to make a transition from inpatient stay or crisis event to community living. Providing this stable living environment along with skills training and supports will reduce
Starting Point/Baseline:
Currently no Transitional Housing program exists in Guadalupe County; therefore, the baseline is 0 in DY 2. Baseline data will be based on patients entering the transitional housing program in DY3.

Rationale:
The Transitional Housing program based on Recovery principles provides an opportunity for those persons discharged from a psychiatric hospital or recently experiencing a behavioral health crisis to have a stable place to live and participate in learning the skills needed to move on to independent or supported living in the community. We selected the “Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services” because assessment of the needs in the County indicate that resources and interventions are lacking to reduce inpatient stays and provide community options after a crisis event. The community-based interventions employed in the project mirror many of those listed as components under this Option; including:

- Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services);
- Psychosocial Rehabilitation;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Transportation to appointments and community-based activities;
- Prescription medications;

Project Components: Even though there are no Core Components associated with this option, we plan to follow the components listed for 2.13.1. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gaps that must be filled to secure housing and to gain the skills for a smooth transition. With these stakeholders, we will identify tools to provide data to get an inventory of community resources currently utilized and those needed by the people we expect to serve. We will use the current staff to assess current needs of those who are now hospitalized and soon to be discharged and those experiencing crisis events needing transition to community housing. Using the information from stakeholders, from capacity and utilization tools, from further literature reviews and from assessment of those potential referrals, we will assess the intervention we are planning to provide. As we implement the project we will plan a rapid cycle quality improvement component through our Quality Management Department at BTCS. We plan to continuously improve the program over the next 5 years as we adjust the interventions, peer supports and make changes based on lessons learned. Those changes may include adjustments to the model with respect to interventions, intensity and population. Continuous Quality Improvement: BTCS is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.
We expect the milestones and metrics in the first 2 years to reflect the innovative and developmental nature of this project. We will measure progress toward community assessment and development of infrastructure such as policies, training materials, contracts and support. These Milestones and Metrics are specifically related to the targeted population of individuals who have recent crisis events that sometimes result in hospitalizations with the aim of providing them the best opportunity to make a recovery oriented transition to the community and thereby prevent further crises and hospitalizations.

BTCS has participated as a member of the Guadalupe County Mental Health Task Force to identify behavioral health gaps and needs. Health disparity is often driven by income disparity. 11% to 20% of the population of Guadalupe County is below the poverty level. Additionally, 24% of the people in the RHP 6 region are without insurance or any third party coverage. The entire county has been designated a health care provider shortage area for behavioral health and for primary care according to US Department of HHS, HRSA. BTCS reviewed data related to admissions to the State Hospital and to the voluntary Crisis Respite facility. We found a large percentage of the 218 year to date admissions to the State Hospital--17% accounting for 37 of the 218 admissions--were made without prior screening and authorization by BTCS, the LMHA. Analysis reveals that those admissions are being taken directly to the hospital by law enforcement officers because they have few local alternatives. Analysis of those State Hospital admissions reveals a substantial number with very short lengths of stay, indicating that they were inappropriately admitted and might be prevented with a community alternative for transitional housing. The number of individuals with lengths of stay less than 3 days reflects that 61 persons may have been inappropriately admitted year-to-date. When we reviewed the admission data for the voluntary Crisis Respite facility, it revealed that there were 252 admissions in FY 2012 and of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. All of these individuals would meet initial eligibility criteria for transitional housing.

This project addresses RHP 6 Community Needs Assessment need CN.4 “There is a shortage of high quality mental and behavioral health services that are integrated with physical health care services.”

BTCS has operated a free-standing mental health outpatient clinic site in Seguin in Guadalupe County for a number of years. We have been engaged in planning with the local FQHC, Community Health Centers of South Central Texas, to build and establish a clinic site that integrates behavioral health care and primary care. This navigation project is enhanced by that delivery system reform. Our planning recently resulted in the award of a grant through the Health Resources and Services Administration Division of the US Department of HHS to develop a primary care/behavioral health care clinic site in Seguin in partnership with the Federally Qualified Health Center for Guadalupe County. These Federal funds will not be used to provide the patient navigation program, but having the integrated clinic will more effectively meet the needs of those we provide navigation services to and provide options for care and a medical home that has heretofore been unavailable. Successful community living requires whole health. Our collaboration increase the opportunities for linkage to primary care and a medical
Related Category 3 Outcome Measure(s):

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
- IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.

Reasons/ rationale for selecting the outcome measure: This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been hospitalized or experienced a crisis event that could have resulted in a hospitalization to transition to stable living in the community. That transition will be made because of the program interventions that improve functioning and the skills needed for successful community living. When the goal is achieved then program participants will self-manage their recovery and wellness and there should be a reduction in symptoms and a reduction in crisis events. The outcome of this is fewer readmissions to the hospital both for 30 days and in the long term.

Relationship to other Projects:
BTCS has also proposed in Category 1, Project 1268443-05.1.2. That project is the establishment of new treatment site for outpatient substance abuse care. The navigation project will be able to refer to services offered through the substance abuse clinic and thereby initiate much needed treatment and reduce returns to the ED. This project fills a gap in services that the patient navigators will need for referral and care.

Relationship to Other Performing Providers’ Projects in the RHP:
BTCS plans to participate in learning collaborative with Center for Health Care Services which is planning integrated care and specialized care management projects. We have contracts with the Center to provide Crisis Respite and Detoxification services. Adjusting these interventions along with the Transitional Housing program will improve potential for success. We expect to meet quarterly with the Center for Health Care Services and other community providers. We would also request to participate with University of Texas Health Science Center, San Antonio and University Health System both of which are planning patient navigation programs.

Plan for Learning Collaborative:
BTCS will participate in all learning collaboratives organized or sponsored by University Health System that are relevant to our projects. As stated by University Health System in guidance to Performing Providers on October 2, 2012, “RHP 6 is committed to transforming health care in our region and throughout the state. Given the large number and value of projects proposed for our region, University Health System, as the RHP 6 anchor, will promote and facilitate learning collaboratives.” As above, we will actively seek participation in other learning collaboratives in the Region. We believe it is important to improving and adjusting the care provided.

Project Valuation:
This project seeks to provide transitional housing services and placement in permanent housing for 12 people in DY 4 and 18 people in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT
Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We assigned a value of $1,313,236 through DY 5. A description of the method used, titled ‘Valuing Transformation Projects,’ has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.
<table>
<thead>
<tr>
<th>1268443-05.2.2 PASS 2</th>
<th>2.13.2</th>
<th>N/A</th>
<th>2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Transitional housing with behavioral supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
<td>TPI - 126844305</td>
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</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>3.IT-3.8</td>
<td>1268443-05.3.4</td>
<td>Behavioral Health /Substance Abuse 30 day readmission rate</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>
| **Milestone 1**  
P-2: Design community-based specialized interventions for target populations.  
Metric 1 P-2.1. Project plans which are based on evidence / experience and which address the project goals.  
Goal: Produce a comprehensive plan documenting data and events guiding project development.  
Data Source: Program documents.  
Milestone 1 Estimated Incentive Payment: $148,559 | **Milestone 3**  
P-3: Enroll and serve individuals with targeted complex needs  
Metric 1 P-3 Number of targeted individuals enrolled / served in the project.  
Goal: Enroll and Serve 8 individuals during DY 3.  
Data Source: Program Records and EHR  
Milestone 3 Estimated Incentive Payment: $163,386 | **Milestone 4**  
P-4. Evaluate and continuously improve interventions  
Metric 1 P-4.1: Project planning and implementation  
Milestone 4 Estimated Incentive Payment: $350,810 | **Milestone 5**  
[I-X]: Number of patient interventions.  
Metric 1 [I-X.1]: Number of patient in target population served at this new transitional housing site.  
Baseline/Goal: Baseline - 0 since no such site is currently located in RHP; Goal - Serve 12 people in DY4.  
Data Source: EHR  
Milestone 5 Estimated Incentive Payment: $338,536 |
| **Milestone 2**  
P-3: Enroll and serve individuals with targeted complex needs  
Metric 1 P-3 Number of targeted individuals enrolled / served in the project.  
Goal: Enroll and Serve 8 individuals during DY 3.  
Data Source: Program Records and EHR  
Milestone 2 Estimated Incentive Payment: $148,559 | **Milestone 3**  
P-3: Enroll and serve individuals with targeted complex needs  
Metric 1 P-3 Number of targeted individuals enrolled / served in the project.  
Goal: Enroll and Serve 8 individuals during DY 3.  
Data Source: Program Records and EHR  
Milestone 3 Estimated Incentive Payment: $163,386 | **Milestone 4**  
P-4. Evaluate and continuously improve interventions  
Metric 1 P-4.1: Project planning and implementation  
Milestone 4 Estimated Incentive Payment: $350,810 | **Milestone 5**  
[I-X]: Number of patient interventions.  
Metric 1 [I-X.1]: Number of patient in target population served at this new transitional housing site.  
Baseline/Goal: Baseline - 0 since no such site is currently located in RHP; Goal - Serve 18 people in DY5.  
Data Source: EHR  
Milestone 5 Estimated Incentive Payment: $338,536 |
<table>
<thead>
<tr>
<th>Metric 1 P-3 Number of targeted individuals enrolled / served in the project.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Enroll and Serve 2 individuals during 6 month period of DY 2.</td>
</tr>
<tr>
<td>Data Source: Program Records and EHR</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $148,559</td>
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</tbody>
</table>

- Documentation demonstrates plan, do, study act quality improvement cycles.  
- Goal: Participate in Quarterly meetings to review data and implement recommendations.  
- Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.  
- Milestone 4 Estimated Incentive Payment: $163,386

| Year 2 Estimated Milestone Bundle Amount: $297,118 |
| Year 3 Estimated Milestone Bundle Amount: $326,772 |
| Year 4 Estimated Milestone Bundle Amount: $350,810 |
| Year 5 Estimated Milestone Bundle Amount: $338,536 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,313,236**
Identifying Project and Provider Information:
Title: 2.13.1 Design, implement and evaluate research supported and evidence-based interventions tailored towards individuals in the target population,
Unique RHP ID#: 137251808.2.1 - PASS 1
Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services
Performing Provider TPI: 137251808

Project Summary:
Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.
Intervention(s): CHCS seeks to expand a therapeutic justice model for persons with serious mental illness as a means of diverting them from being placed in the criminal justice system whether through institutionalization or adjudication. Points of entry into services will include mental health assessors stationed at the Magistrate Court providing screening and assessment of self-referrals or system referrals. Those identified with behavioral health needs are referred under judicial order to the specialized outpatient program, which features targeted interventions for this hard to serve population, in lieu of incarceration. The services to be provided are community based mental health services provided in the community and not provided in the criminal justice jail site. As an alternative to hospitalization or incarceration, this is a cost efficient approach and connects patients to appropriate treatment in a more durable fashion. This population is differentiated from a general adult mental health outpatient population by their demonstrated reticence to access care and their historical failures to comply with care recommendations; the basis of a therapeutic justice model. Evidence-based practice research indicates that the presence of court ordered monitoring improves compliance and treatment outcomes. There is an estimated 25% difference between available funding for current capacity and demonstrated need. A consistent, coordinated, service-rich continuum of care for adults with mental illness, key components of a therapeutic justice model will ensure positive, long-term improvements in mental health, quality of life, functioning and stability, and will provide appropriate alternatives to incarceration.
Need for the project: Diverting adults with behavioral health disorders into treatment rather than incarceration is an evidence-based, cost-effective practice. CHCS has implemented a variety of therapeutic justice programs targeting adults with serious mental illness, which have shown positive outcomes; however, CHCS is currently providing these services at 25% above capacity and significant numbers of otherwise eligible adults are going un-served or experiencing a lengthy wait for treatment.
Target population: Adults with a behavioral health disorders. Based upon current service data, it is anticipated that 54% of those to be served will be indigent and 44% will be covered by Medicaid.
Category 1 or 2 expected patient benefits: The project seeks to divert adults with serious mental illness from institutionalization or incarceration and into treatment and readmissions. In DY4 the percentage of individuals who demonstrate improved functional status on standardized instruments (e.g., ANSA, CANS, etc) will improve from a base line of 295 served in DY3, by 50%, totaling 148 individuals and in DY5, 75%, totaling 221 individuals will demonstrate improved functional status on standardized instruments.
Category 3 outcomes: IT-9.1. Our goal, which will be quantified by DY4, is to decrease mental
Project Description:

The Center For Health Care Services (CHCS) seeks to increase the availability of mental health support services for mentally ill persons as a means of diverting them from institutionalization or incarceration and into treatment. Only a fraction of the medically indigent population can be served and there is a wait time of up to three months for persons needing this type of treatment. Compounding the issue is the need to establish a sufficient continuum of care for persons who are exiting crisis services. Linkages to specialized, community-based services will reduce the number of subsequent crises.

Bexar County and The Center for Health Care Services recognizes the need for expeditious and effective mental health treatment and stabilizing supports for this target population, including the subset that becomes involved with the criminal justice system. Expansion of existing services and further implementation of the therapeutic justice approaches for this target population must include additional mental health, substance-abuse and support services components if we are to stabilize mental health, restore community functioning and improve quality of life while simultaneously reducing cyclic acute episodes.

Goals. Reduce the number of adults with serious mental illness who repetitively cycle through the criminal justice and courts system by expanding the availability of specialized services designed to promote treatment engagement and prevent unnecessary incarceration and utilization of emergency departments and urgent care facilities. Provide an intervention for adults with serious mental illness to promote treatment engagement and prevent unnecessary incarceration and the utilization of emergency departments and urgent care facilities. Reduce the number of adults with serious mental illness who repetitively cycle through the criminal justice, acute inpatient and other costly systems. Maintain adults in treatment for a minimum of one year.

Challenges addressed by the project. Diverting adults with a behavioral health disorder into treatment rather than institutionalization or incarceration is an evidence-based, cost-effective practice. In a limited study, CHCS examined the expense associated with members of the target population who received psychiatric in-jail services during a one year period ($3,058,000) versus the same target population receiving community-based therapeutic justice services in lieu of incarceration ($497,000). A $2,561,000 cost savings was verified. While CHCS interventions have shown positive outcomes, we are currently operating at 25% above capacity and significant numbers of otherwise eligible adults are going un-served or experiencing a lengthy wait for treatment. In the absence of rapidly responsive treatment services, the members of the target population also often experience extended or repeated stays at inpatient psychiatric facilities.

5-year expected outcomes for CHCS. CHCS seeks to provide specialized diversion services in an outpatient clinic that will be easily accessed for this population and allow for expanded access to psychiatric and related clinical services.

5-year expected outcomes for persons served by the project.

Improved access to services, including: 1) significantly reduced waiting time for physician appointments, which will improve patient satisfaction and compliance, and reduce adverse outcomes attributable to the lack of timely access to care. 2) improved compliance with scheduled appointments resulting from timely access. 3) urgent care for medication management and related health admissions and readmissions to criminal justice settings.
Relation to Regional Goals. Expanding resource availability to address the dearth of intensive outpatient mental health services is a key means of achieving the regional goal of “Improving the infrastructure for delivery of behavioral health services”. The program fills an existing gap in care and improves the existing behavioral health infrastructure to better serve Medicaid and uninsured adults in Bexar County while containing cost growth.

Starting Point/Baseline:
244 unduplicated adults per year

Rationale:
The project option 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population, process milestone (P-3: Enroll and serve individuals with targeted complex needs (i.e., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) was selected in correspondence to an existing, unmet need for additional services for integrated care among adults with serious mental illness, frequent co-occurring behavioral and physical health problems and involvement with the criminal justice and courts systems. The target population often has a complex combination of physical and behavioral health care needs. Community mental health facilities are the right place for the mentally ill with complex behavioral health issues to access specialized care and treatment. When such services are sufficiently available and easily accessed, persons with mental illness will experience an improved quality of life. Consequently, sufficient access to services in the community for persons with mental illness will: a) positively impact their quality of life by ensuring that they will receive consistent, appropriate treatment in the right setting; b) reduce the likelihood that adults with mental illness will be less likely to inappropriately enter the criminal justice or court system; and, c) promote wellness and adherence to medication and other treatment modalities, which will promote recovery and stability in the community.

Project Components: a). Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. b). Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. d) Design models which include an appropriate range of community-based services and residential supports. e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

Unique community need identification numbers the project addresses:
CN.4 - Inadequate mental health services results in avoidable costs to hospital and criminal and juvenile justice systems. The RHP 6 Community Needs Assessment also cited information from the Bexar County Health Collaborative Community Health Improvement plan that includes the following facts.

- About 6 people per 1000 are hospitalized for mental disorders every year in Bexar
County.

- About 1 person in 10,000 dies every year in Bexar County due to suicide.
- Adjusted for age, in 2008, this rate added up to 245 years of potential life lost per 100,000 under age 65 due to suicide for the residents Bexar County.
- The goal of the improvement plan is to improve comprehensive behavioral health services and access for all.

According to RHP6 Community Needs Assessment, inadequate services for individuals who have been arrested or incarcerated either as a result of or precipitated by unmet behavioral health needs remain a concern in Bexar County.

The proposed project will positively impact issues identified by UHS as Mental and Behavioral Health Unique Needs, identification number:

**How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Significant enhancement

**Related initiatives funded by U.S. Department of HHS:** None

### Related Category 3 Outcome Measure(s):

- OD-9 Right Care Right Setting.
- IT-9.1 Decrease in Mental Health Admissions and readmissions to criminal justice settings such as jails or prisons.

**Reasons/rationale for selecting the outcome measures:** Twenty percent of the Bexar County Adult Detention Center (BCADC) population includes persons with mental illness. The right place for consistent clinical therapeutic mental health treatment is not BCADC or local emergency rooms; the right place is a community-based mental health facility. The lack of access to a therapeutic justice system makes adults with serious mental illness more vulnerable to repetitively entering the criminal justice and courts systems, adversely impacting quality of life, and increasing vulnerability. Since the mentally ill are over-represented in low-income populations, improvement in community based treatment and services will benefit a significant share of persons in poverty.

### Relationship to other Projects:

The proposed project will address significant behavioral health care resource insufficiency in Bexar County. As such, it is an integral component of this County’s health care infrastructure. Another proposed project seeks to establish research-based care for a segment of the population of adults with mental illness. These resources will be coordinated with CHCS’s proposed service expansion, if appropriate, to build a more durable continuum of care.

### Relationship to Other Performing Providers’ Projects in the RHP:

UTHSCA is proposing a potentially similar project. CHCS will join any collaborative learning communities with UTHSCA or other providers dedicated to serving adults with mental illness.

### Plan for Learning Collaborative:

CHCS will participate in any and all relevant learning collaboratives organized by University Health System.

### Project Valuation:

886 ★ RHP 6 Plan ★ March 8, 2013  
Center for Health Care Services
The value for this project is $3,618,510 for DY 2 and $15,152,433 for all years. A total of 295 adults will be served by the program by the end of DY3. The proposed service expansion increases accessibility of behavioral health care for adults. Additionally, the availability of the proposed resource will ensure adults with mental illness are treated expediently, connected to systems of care that support community living and not institutionalized or incarcerated inappropriately. Services and treatment provided will demonstrate that 75% of the individuals served, 221 consumers will demonstrate improved functional status. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of therapeutic justice services, in lieu of institutionalization or incarceration, has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.2.1 PASS 1</th>
<th>2.13.1</th>
<th>2.13.1</th>
<th>2.13.1 Design, implement and evaluate research supported and evidence-based interventions tailored towards individuals in the target population</th>
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<tr>
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<td>TPI - 137251808</td>
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<td>Related Category 3 Outcome Measure(s):</td>
<td>137251808.3.6</td>
<td>3.IT-9.1</td>
<td>Decrease in Mental Health Admissions and readmissions to criminal justice settings such as jails or prisons</td>
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</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
P-3: Enroll and serve individuals with targeted complex needs (i.e., a diagnosis of severe mental illness with concomitant chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities)

- **Metric 1**
  - P-3.1: Number of targeted individuals enrolled or served.
  - Baseline: 244
  - Goal: 268
  - Data Source: client records

**Milestone 2**
P-3: Enroll and serve individuals with targeted complex needs (i.e., a diagnosis of severe mental illness with concomitant physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities)

- **Metric 1**
  - P-3.1: Number of targeted individuals.
  - Baseline/Goal: 295
  - Data Source: client records

**Milestone 1 Estimated Incentive Payment:** $3,774,893

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3**
I-5: Functional status.

- **Metric 1**
  - Percentage of individuals who demonstrate improved functional status on standardized instruments (e.g., ANSA, CANS, etc.)
  - Goal: 148 (50%)
  - Data Source: Client records

**Milestone 3 Estimated Incentive Payment:** $4,038,257

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4**
I-5: Functional status.

- **Metric 1**
  - Percentage of individuals who demonstrate improved functional status on standardized instruments (e.g., ANSA, CANS, etc.)
  - Goal: 221 (75%)
  - Data Source: Client records

**Milestone 4 Estimated Incentive Payment:** $3,901,698

### Year 5 (10/1/2015 – 9/30/2016)

- **Milestone 3 Estimated Incentive Payment:** $4,038,257
- **Milestone 4 Estimated Incentive Payment:** $3,901,698
<table>
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<tr>
<th>Year 2 Est. Milestone Bundle Amount: $3,437,585</th>
<th>Year 3 Estimated Milestone Bundle Amount: $3,774,893</th>
<th>Year 4 Estimated Milestone Bundle Amount: $4,038,257</th>
<th>Year 5 Estimated Milestone Bundle Amount: $3,901,698</th>
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<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,152,433</strong></td>
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**Identifying Project and Provider Information:**

| Title: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: PCY Integrated Clinic  
| Unique RHP ID#:137251808.2.2 – PASS 1  
| Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services  
| Performing Provider TPI: 137251808 |

**Project Summary:**

Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

Intervention(s): CHCS seeks to establish a comprehensive, integrated care management center offering primary and behavioral health care to homeless adults living at Prospects Courtyard (PCY) within the Haven for Hope campus. The great majority will have co-occurring mental health and/or substance use and chronic physical disorders. CHCS, with funding from local public and private stakeholders, has established an on-site psychiatric clinic that has exceeded service expectations and continues to grow in utilization and positive impact; however, there remains a critical need for on-site primary care. The new integrated care clinic will provide walk-in triage, preliminary diagnostics, initial treatment, referral and follow up for medical care, psychiatric care, urgent care, medication management, immunizations, and chronic disease prevention strategies. A health navigator will support treatment compliance through evidenced-based practices, such as motivational interviewing. Also, commonly used medication will be available, a significant unmet need for the target population and a major contributing factor to their physical and behavioral health problems. The easily accessed, integrated care clinic will foster greater stability and compliance with recommended treatment by a frequently treatment-averse target population, which in turn will reduce crises and the inappropriate utilization of emergency department (ED) services. Most patients will be uninsured despite their eligibility for Medicaid because they lack a permanent address.

Need for the project: PCY sleeps more than 600 adults per night and cares for more than 700 during the day. The initial goal was to provide a safe sleeping environment, three meals a day and access to showers and bathrooms but it quickly became apparent that untreated physical and behavioral health problems were inextricably tied for the target population. Also, it is well documented that homeless populations routinely access primary health care through hospital emergency departments (ED), a costly approach and a major contributor to congestion and over-crowding in urban EDs.

Target population: Homeless adults with untreated physical and behavioral health disorders. These adults can be expected to have significant, chronic physical and behavioral health problems and all will be extremely low income. Most will repetitively cycle through the San Antonio State Hospital and/or University Hospital. Based upon current service information, 16% of the target population will be funded by Medicaid and 57% will be indigent and uninsured.

Category 1 or 2 expected patient benefits: The project seeks to ensure that in DY4, a baseline of 500 residents will receive services and a goal of 125 individuals or 25% will receive integrated services and in DY5, 175 or 35% of baseline will receive integrated care.
Category 3 outcomes: IT-9.2. Our goal, which will be quantified in DY4, is to increase the appropriate utilization of area EDs.

**Project Description:**

The Center For Health Care Services (CHCS) seeks to establish a comprehensive, integrated care management center offering primary and behavioral health care at Prospects Courtyard (PCY) within the Haven for Hope campus. The target population will consist of homeless adults living at PCY with co-occurring mental health and/or substance use and chronic physical disorders. CHCS, with funding from local public and private stakeholders, has established an on-site psychiatric clinic that has exceeded service expectations and continues to grow in utilization and positive impact; however, there remains a critical need for on-site primary care.

The new integrated care clinic will provide walk-in triage, preliminary diagnostics, initial treatment, referral and follow up for medical care, psychiatric care, urgent care, medication management, immunizations, and chronic disease prevention strategies. A health navigator will be provided to support treatment compliance through evidenced-based practices, such as motivational interviewing. Also, commonly used medication will be available, a significant unmet need for the target population and a major contributing factor to their physical and behavioral health problems.

The easily accessed, integrated care clinic will foster greater stability and compliance with recommended treatment by a frequently treatment-averse target population, which in turn will reduce crises and the inappropriate utilization of emergency department (ED) services. The great majority of those who will be served are uninsured despite their eligibility for Medicaid because they lack a permanent address.

**Goals.** Improve health outcomes by delivering the right care at the right time and the right place. Increase use of preventive, primary and specialty care. Decrease use of costly ED and inpatient care.

**Challenges addressed by the project.** PCY, initially designed to accommodate 400 homeless adults (June 2010), has grown to sleeping more than 600 at night and caring for more than 700 during the day. The initial goal was to provide a safe sleeping environment, three meals a day and access to showers and bathrooms. However, it quickly became apparent that untreated physical and behavioral health problems were inextricably tied for the target population, with one undermining stability and improvement of the other. For example, Texans with severe and persistent mental illness die 28 years sooner than the general population. And the most frequent causes of death, e.g., diseases of the circulatory system, can be effectively addressed through early intervention and primary care that is integrated with behavioral health care.

Also, it is well documented that homeless populations routinely access primary health care through hospital emergency departments (ED), a costly approach and a major contributor to congestion and over-crowding in urban EDs. The primary means of getting to an ED is EMS and in 2011, the City of San Antonio’s EMS responded to 950 emergency calls at Haven for Hope, resulting in approximately 600 transports to area hospital EDs. Two-thirds of these calls were in the evening, signaling the need for extended clinic hours.

It is reported that 9 PCY residents have died in the last year. Reducing costs for area EDs and EMS are worthy goals but both are superseded by the need to avert the tragic loss of life and functioning associated with untreated behavioral and physical illnesses among homeless adults.
5-year expected outcomes for CHCS. Development of an integrated care management center to be oriented around the patient so that primary care access and the patient experience can be improved. Decreased emergency room visits. Decreased use of emergency detoxification services. Decrease 911, psychiatric crisis and triage calls. Decreased utilization of emergency transportation services. Decreased utilization of State and crisis transitional psychiatric beds
5-year expected outcomes for persons served by the project. Increased preventive behavioral health behaviors (e.g. vaccinations, nutrition, and hygiene). Improved overall primary, mental, and behavioral health outcomes
Relation to Regional Goals. Psychiatric triage and primary care are available within two blocks of PCY but residents will not consistently utilize these resources. Therefore, the proposed project supports achievement of the regional goal of “Integrating behavioral health with physical health and other evidence-based services and supports”. It also meets the CMS three part aim, as follows. The program enables and ensures individualized, patient-centered care. The program fills an existing gap in care and improves the existing behavioral health infrastructure to better serve Medicaid and uninsured adults in Bexar County.

Starting Point/Baseline:
Integrated behavioral and physical health care is not currently available to the target population. However, as previously mentioned, it is known that the City of San Antonio’s EMS made over 600 transports to EDs for all Haven for Hope residents. It is unknown how many of these were PCY residents.

Rationale:
The project option (2.15.1 Design, implement and evaluate projects that provide integrated primary and behavioral health care services), process milestone (P-6 Develop integrated behavioral health and primary care services within co-located site) and improvement milestone (I-8.1 % of individuals receiving both physical and behavioral health care at the established location) were selected in correspondence to an existing, unmet need for integrated care among homeless adults. The target population often has a complex combination of physical and behavioral health care needs combined with concomitant issues of substance abuse, traumatic injury, cognitive challenges and a lack of daily living skills and natural supports, causing them to be frequent users of public health services. This project will expand the capacity of currently available treatment options and will install a new, integrated treatment methodology in an effort to avert outcomes such as the inappropriate use of emergency departments and potentially avoidable inpatient admission and readmission, and to promote recovery in the community.

Project Components: Through the PCY Integrated Clinic Care service, we propose to meet all required project components. a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider interaction; ability / willingness to integrate and share data electronically; receptivity to integrated team approach. b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. d) Recruit a number of specialty providers (physical health, mental health,
substance abuse, etc. to provide services in the specified locations. e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include: Regular consultative meetings between physical health and behavioral health practitioners; Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or, Shared treatment plans co-developed by both physical health and behavioral health practitioners. f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project. g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. h) Arrange for utilities and building services for these settings. i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Unique community need identification numbers the project addresses:**

- CN.1 - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- CN.4 - There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

More specifically, the proposed project will positively impact the following:

- Need for integrated behavioral health and primary care services
- Inadequate access to care management and resource navigation
- Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders
- Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments

**How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Significant enhancement. Currently, the targeted population of homeless adults does not receive or access consistent primary care and, as a result, are over-represented among individuals with preventable, often life-threatening illnesses. The initiative will remove access barriers for and reduce incidence rates of chronic diseases.

**Related initiatives funded by U.S. Department of HHS:** CHCS recently received a Health Care Innovation grant from CMS to test and verify the efficacy of a specific integrated care model for the same target population. Details follow.

**Total budget:** $4,557,969 for a 36-month project period
**Number of projected participants:** 260 for 36-month project period
**Cost of care savings:** 34.57% savings PBPY

**Fund use:** Staffing the integrated care clinic, evaluation, workforce development training,
health care supplies. The significant enhancement of this project will allow for services to be provided outside of the 260 participants identified above.

**Project Goals:** Improve health care for target intervention population with complex behavioral and physical health disorders. Improve behavioral and physical health outcomes for target population. Lower the health care costs of the target population.

<table>
<thead>
<tr>
<th><strong>Related Category 3 Outcome Measure(s):</strong></th>
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</thead>
<tbody>
<tr>
<td>OD-9 Right Care</td>
</tr>
<tr>
<td>Right Setting, IT-9.2 ED appropriate utilization.</td>
</tr>
</tbody>
</table>

**Reasons/rationale for selecting the outcome measures:** This measure is indicative of consumers receiving easily accessed care when it is needed most, a critical means of addressing emergent issues and reducing inappropriate use of emergency departments.

**Relationship to other Projects:**
There are multiple projects proposed for RHP 6 that could support or be supported by the PCY Integrated Care Clinic, including increased training of the primary care workforce (1.2), implementation of a chronic disease registry (1.3), introduce, expand or enhance telemedicine/telehealth (1.7), and expand chronic care management models (2.2).

**Relationship to Other Performing Providers’ Projects in the RHP:**
There are no similar projects proposed for implementation in RHP 6. However, CHCS will participate in any relevant learning communities organized by University Health System.

**Plan for Learning Collaborative:**
CHCS will participate in any and all relevant learning collaborative organized by University Health System.

**Project Valuation:**
The value for this project for DY 2 is $1,538,919 and $6,783,356 for all years. By DY5, 175 homeless individuals with significant, chronic physical and behavioral health problems will receive integrated care every year through the proposed PCY Clinic. The establishment of integrated care at PCY fills an existing gap in the local continuum of behavioral health care for high need adults and frequent utilizers of public health care resources. Chronically mentally and physically ill adults will have access to the care required to improve status and stabilize in both domains, which will prevent or reduce costly, avoidable hospitalization and the inappropriate use of emergency departments. CHCS has significant existing infrastructure from which this project can be launched and only site preparation is required, driving down the required investment and increasing cost effectiveness.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.
The annual value of benefits provided to those served by the PCY Clinic at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of the PCY Clinic has the potential to increase QALY among those it serves.
<table>
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<th>137251808.2.2 PASS 1</th>
<th>2.15.1</th>
<th>2.15.1.A</th>
<th>2.15 Design, Implement, and Evaluate Projects that Provide Integrated Primary and Behavioral Health Care Services: PCY Integrated Clinic</th>
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<td>Center for Health Care Services</td>
<td>TPI - 137251808</td>
<td></td>
<td></td>
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<tr>
<td>Related Category 3 Outcome Measure(s): OD-9</td>
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<td>3.1T-9.2</td>
<td>ED appropriate utilization</td>
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### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
- P-6: Develop integrated behavioral health and primary care services within collocated sites
  - Metric 1 P-6.1 Number of providers achieving Level 4 of interaction
    - Baseline: 2 prescribers staff the psychiatric and primary care clinics
    - Goal: 2 or 100% of baseline achievement close collaboration (Level 4)
      - Data Source: Project Data
  - Milestone 1 Estimated Incentive Payment: $1,538,919

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 2**
- P-6: Develop integrated behavioral health and primary care services within collocated sites
  - Metric 1 P-6.2 Number of providers achieving Level 5 of interaction
    - Goal: 2 prescribers achieve full integration (Level 5)
      - Data Source: Project Data
  - Milestone 2 Estimated Incentive Payment: $1,689,923

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 3**
- I-8: Integrated services
  - Metric 1: I-8.1. % of individuals receiving both physical and behavioral health care at the established location.
    - Baseline: 500 residents will receive services
    - Goal: 125 or 25% of baseline will receive integrated services
      - Data Source: Project Data.
  - Milestone 3 Estimated Incentive Payment: $1,807,824

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 4**
- I-8: Integrated services
  - Metric 1: I-8.1. % of all patients receiving integrated care.
    - Goal: 175 or 35% of baseline will receive integrated services
      - Data Source: Project Data.
  - Milestone 4 Estimated Incentive Payment: $1,746,690

### Year 2 Estimated Milestone Bundle Amount: $1,538,919

### Year 3 Estimated Milestone Bundle Amount: $1,689,923

### Year 4 Estimated Milestone Bundle Amount: $1,807,824

### Year 5 Estimated Milestone Bundle Amount: $1,746,690

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,783,356
Identifying Project and Provider Information:

Title: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: Integrated Primary Care for SA and HIV Population
Unique RHP ID#:137251808.2.3 – PASS 1
Performing Provider: The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services
Performing Provider TPI: 137251808

Project Summary:

Provider Description: Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

Intervention(s): The Center For Health Care Services (CHCS) seeks to embed and integrate primary care services at the Restoration Center, a comprehensive substance abuse treatment facility. Adults served at the Restoration Center will experience enhanced access to primary care, including health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. Frequent co-morbidity of medical conditions and drug dependency among existing Restoration Center consumers verifies the appropriateness of the approach. CHCS’ Restoration Center serves up to 10,000 individuals annually with approximately half needing some physical health care during their period of treatment. Additionally, they commonly require support for enrollment in benefit programs (e.g., Medicaid), referrals for specialty care, and access to medications at low or no cost until health insurance coverage can be obtained.

This is a cost effective service as it diverts adults away from over-crowded emergency departments. The proposed project will expand and scale up an existing Clinic by providing a person-centered health care home for adult consumers of substance abuse and mental health services and their families when they are involved in their care. Results of integrated care will include better functioning in both domains, improved behavioral and physical health outcomes any lower costs to the community.

Need for the project: Individuals who utilize substance use treatment and other behavioral health treatments, including those with HIV and pregnant women, often have untreated physical health conditions. In the absence of integrated physical and behavioral health care, these conditions have the potential to worsen and ultimately require more expensive tertiary care and hospitalization.

Target population: Adults with substance abuse with or without other behavioral health disorders and who also have or are at risk for HIV, are pregnant or have other physical health problems. Based upon current service statistics, it is anticipated that 25% will be covered by Medicaid and 48% will be indigent and uninsured.

Category 1 or 2 expected patient benefits: The project seeks to ensure that in DY4, a goal of 1,250 patients with dual health care needs will receive integrated care of 5,000 total patients with dual health care needs and in DY5, 1,750 patients with dual health care needs will receive integrated care of the 5,000 total patients.

Category 3 outcomes: IT-9.2. Our goal for increasing the appropriate utilization of ED resources will be established in DY4.
Project Description:
The Center For Health Care Services (CHCS) seeks to embed and integrate primary care services at the Restoration Center, a comprehensive substance abuse treatment facility. Adults served at the Restoration Center will experience enhanced access to primary care, including health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. Frequent co-morbidity of medical conditions and drug dependency among existing Restoration Center consumers verifies the appropriateness of the approach. CHCS’ Restoration Center serves up to 10,000 individuals annually with approximately half needing some physical health care during their period of treatment. Additionally, they commonly require support for enrollment in benefit programs (e.g., Medicaid), referrals for specialty care, and access to medications at low or no cost until health insurance coverage can be obtained. This is a cost effective service as it diverts adults away from over-crowded emergency departments. The proposed project will expand and scale up existing Clinic and increase hours of operation to 24 hours. Results will include better behavioral and physical health outcomes at a lower cost to the community.

Goals. Improve health care by improving consumers’ capacity to participate and self-manage. Improve health outcomes by delivering the right care (behavioral then physical) at the right time (once stability and sobriety are achieved) and the right place (behavioral health clinic). Lower the cost of care. Increase ease of access and coordination of care for individuals served.

Challenges addressed by the project. Individuals in need of substance abuse and other behavioral health treatment, including those with HIV or pregnant women, often have untreated physical health conditions. In the absence of integrated physical and behavioral health care, these conditions have the potential to worsen and ultimately require more expensive tertiary care and hospitalization.

CHCS’ Restoration Center features Residential and Ambulatory Detoxification, Outpatient Substance Abuse Services, Opioid Addiction Treatment Outpatient Services, Sobering Unit, Sober Living Dorms and a Crisis Care Center. The majority of consumers served are episodically homeless and many are chronically homeless. At least 50% also suffer from a co-occurring mental illness and one or more chronic physical illnesses, e.g., cardiovascular disease, diabetes, stroke, cancer, HIV/AIDS, hepatitis and lung disease. Each of these illnesses has a higher prevalence among substance abuse patients, whose diminished capacity limits self-care and follow through. These consumers also are likely to perpetually cycle through emergency departments, substance abuse treatment settings, crisis care services and shelters. In San Antonio, roughly 45% of these high acuity patients are eligible for Medicaid but they are unable to navigate through either the behavioral or physical health systems, causing them to be largely untreated until symptom acuity necessitates a call for an ambulance and a trip to an emergency department.

5-year expected outcomes for CHCS. Development of an integrated care management center to be oriented around the patient so that primary care access and the patient experience can be improved. Decreased emergency room visits. Decreased use of emergency detoxification services. Decreased 911 calls. Decreased utilization of emergency transportation services.

5-year expected outcomes for persons served by the project. Increased preventive health
behaviors (e.g. vaccinations, nutrition, hygiene). Improved overall primary and behavioral health outcomes. Improved physical health status of HIV patients receiving primary care.

Relation to Regional Goals. Single-site, integrated primary and behavioral health care is believed to be an innovative approach as it first stabilizes the individual’s behavioral health and then enables him or her to participate in and remain compliant with primary care, including chronic disease prevention or treatment. Therefore, the proposed project supports achievement of the regional goal of “Integrating behavioral health with physical health care services in order to improve care and access to needed services” by addressing a population with problems substance use that is largely ignored in other settings. It also meets the CMS three part aim, as follows. The program enables and ensures individualized, patient-centered care. The program fills an existing gap in care and improves the existing behavioral health infrastructure to better serve Medicaid and uninsured adults in Bexar County and creates cost savings through reduced use of emergent and urgent care.

Starting Point/Baseline:
Integrated behavioral and physical health care is not currently available to the target population.

Rationale:
The project option (2.15.1 Design, implement and evaluate projects that provide integrated primary and behavioral health care services), process milestone (P-6 Develop integrated behavioral health and primary care services within co-located site) and improvement milestone (I-8.1 % of individuals receiving both physical and behavioral health care at the established location) were selected in correspondence to an existing, unmet need for integrated care among adults with co-occurring substance use, behavioral and physical health problems. The target population often has a complex combination of physical and behavioral health care needs combined with concomitant issues of substance abuse, traumatic injury, cognitive challenges and a lack of daily living skills and natural supports, causing them to be frequent users of public health services. This project will expand the capacity of currently available treatment options and will install a new, innovative sequential treatment methodology in an effort to avert outcomes such as potentially avoidable inpatient admission and readmission, and to promote recovery in the community.

Project Components:
Through the Integrated Primary Care for Substance Abuse and HIV population service, we propose to meet all required project components. a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider interaction; ability / willingness to integrate and share data electronically; receptivity to integrated team approach. b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations. e) Train physical and behavioral health providers in protocols, effective communication and team
approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include: Regular consultative meetings between physical health and behavioral health practitioners; Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or Shared treatment plans co-developed by both physical health and behavioral health practitioners. f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project. g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. h) Arrange for utilities and building services for these settings. i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Unique community need identification numbers the project addresses:**

- **CN.1** - Texas ranks last in the nation on health care quality. RHP 6 is challenged to deliver improved quality and patient satisfaction.
- **CN.4** - There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

More specifically, the proposed project will positively impact the following issues:

- Need for integrated behavioral health and primary care services
- Inadequate access to care management and resource navigation

How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: Significant enhancement. Currently, Integration for Primary Care for Substance Abuse and HIV population is not available through the community mental health system. The initiative will improve access for targeted patients while helping the system by reduction of primary care illness that otherwise would not be treated. (needs more work).

Related initiatives funded by U.S. Department of HHS.

Funding which was received from SAMHSA for a similar project, Project Carino, terminated in early 2013 and there is no current federal funding by U.S. Department of HHS.

**Related Category 3 Outcome Measure(s):**

- OD-9 Right Care, Right Setting
- IT-9.2 ED appropriate utilization.

**Reasons/rationale for selecting the outcome measures:** This measure is indicative of consumers receiving easily accessed care when it is needed most, a critical means of addressing emergent issues and reducing inappropriate use of emergency departments.

**Relationship to other Projects:**

CHCS is the only provider proposing an integrated behavioral and primary health care project for adults with substance use disorders in RHP 6. However, this project will
benefit from other proposed interventions and infrastructure capacity enhancements, including increased training of the primary care workforce (1.2) available to staff the proposed project and the development of workforce enhancement initiatives to support access to behavioral health providers (1.14).

**Relationship to Other Performing Providers’ Projects in the RHP:**

There are no similar projects proposed in RHP 6.

**Plan for Learning Collaborative:**

CHCS will participate in any and all relevant learning collaborative organized by University Health System.

**Project Valuation:**

The value for this project for DY 2 is $1,678,820 and $7,400,024 for all years. By DY5, 1,750 individuals will receive integrated behavioral and physical health care. The establishment of integrated care for adults receiving substance abuse treatment, who may be HIV+ and receiving care fills an existing gap in the local continuum of behavioral health care for high need adults and frequent utilizers of public health care resources. The availability of this new resource will ensure adults receive the treatment they need in an easily accessed location with the capacity to meet needs in both health domains, which will prevent or reduce costly, avoidable hospitalization and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or
outcome, is the number of life-years added.

The CUA calculations indicate that the availability of integrated care has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.2.3 PASS 1</th>
<th>2.15.1</th>
<th>2.15.1.A-J</th>
<th>2.15.1 DESIGN, IMPLEMENT, AND EVALUATE PROJECTS THAT PROVIDE INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES: INTEGRATED PRIMARY CARE FOR SA AND HIV POPULATION</th>
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<tr>
<td>Center for Health Care Services</td>
<td>TPI - 137251808</td>
<td>Related Category 3 Outcome Measure(s): 137251808.3.8 3.IT-9.2 ED appropriate utilization</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1**

**P-6: Develop integrated behavioral health and primary care services within collocated sites**

**Metric 1** P-6.1 Number of providers achieving Level 4 of interaction

*Baseline: Five physicians, one physician assistant, two advanced nurse practitioners.*

*Goal: Achievement of close collaboration (Level 4) by 50% of prescribers.*

*Data Source: Project Data, CPT codes.*

*Milestone 1 Estimated Incentive Payment: $1,678,820*

**Milestone 2**

**P-6: Develop integrated behavioral health and primary care services within collocated sites**

**Metric 1** P-6.2 Number of providers achieving Level 5 of interaction

*Goal: Achievement of full integration (Level 5) by 100% of prescribers.*

*Data Source: Project Data, CPT codes.*

*Milestone 2 Estimated Incentive Payment: $1,843,552*

**Milestone 3**

**I-8: Integrated services**

**Metric 1:** I-8.1 % of all patients receive integrated care.

*Goal: 1,250 patients with dual health care needs will receive integrated care (of 5,000 total patients with dual health care needs).*

*Data Source: Project Data, CPT codes.*

*Milestone 3 Estimated Incentive Payment: $1,972,172*

**Milestone 4**

**I-8: Integrated services**

**Metric 1:** I-8.1 % of all patients receive integrated care.

*Goal: 1,750 patients with dual health care needs will receive integrated care (of 5,000 total patients with dual health care needs).*

*Data Source: Project Data, CPT codes.*

*Milestone 4 Estimated Incentive Payment: $1,905,480*

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,400,024**
<table>
<thead>
<tr>
<th>Identifying Project and Provider Information:</th>
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<tbody>
<tr>
<td><strong>Title:</strong> 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Coordinated Community Integrated Care Response for Super-Utilizing Consumers-Expand and Enhance Pilot Project</td>
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<tr>
<td><strong>Unique RHP ID#:</strong> 137251808.2.4 – PASS 2</td>
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<tr>
<td><strong>Performing Provider:</strong> The Bexar County Board Of Trustees for Mental Health Mental Retardation Services, d/b/a/ The Center For Health Care Services</td>
</tr>
<tr>
<td><strong>Performing Provider TPI:</strong> 137251808</td>
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<table>
<thead>
<tr>
<th>Project Summary:</th>
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<tbody>
<tr>
<td><strong>Provider Description:</strong> Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.</td>
</tr>
<tr>
<td><strong>Intervention(s):</strong> This project results from a collaborative planning effort among area hospitals and CHCS to identify and engage in treatment adults with significant unmet behavioral and physical health care needs who perpetually cycle through the community’s emergency departments (ED) and inpatient psychiatric facilities. This population will be most efficiently served, will more likely recover and, as a result their quality of life will improve, if their providers collaboratively plan for their needs. To this end, CHCS is developing protocols and a shared cloud-based data platform that will enable ED staff to quickly verify that a patient is a super-utilizer and gain access to the community treatment plan. If the individual has been lost from care, e.g., has not filled prescriptions or made recent therapy appointments, they will be reconnected to their treatment team before leaving the ED. Also, because all members of the target population have complex health concerns with a history of substantial reliance on acute and sub-acute care, CHCS will expand treatment to encompass a holistic perspective, including integrated primary and behavioral health care and clinical and organizational alignment with other community providers involved in care. Project staff will be trained in the chronic care wellness and integrated care models to provide effective, evidence-based treatment to the patient population. An important attribute of the proposed project is that it is patient-centered and <em>in vivo</em>, meeting the patient where he or she is in terms of clinical presentation, readiness for engagement and change, need, and physical location. Service selections will be based on the results of comprehensive assessment and integrated treatment planning will ensure linkage to primary medical, mental health and substance abuse treatment services. A trauma-informed service delivery system will be used. Additional supports will include transition services to foster stability, peer support, specialized therapies, medical services, and residential options. The program will operate in the context of the recovery model in which the individual is encouraged and empowered to take an active role in his or her health and treatment, and is provided with tools and supports to achieve individual goals.</td>
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</table>
| **Need for the project:** Targeted individuals are not reliably engaged in appropriate, effective or efficient behavioral or primary health care that will ensure their needs are met or that stability and community functioning is restored. In addition to experiencing sub-standard outcomes for their own health, their inappropriate over-utilization of acute and sub-acute care results in the diversion of health care dollars that could be more effectively deployed, exacerbating the health care resource deficit in Bexar County. Historically,
Target population: The target population consists of adults with severe mental illness and other factors -- e.g., chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement -- that produce an over-reliance on and over-utilization of emergency departments and psychiatric facilities and inpatient hospitals. Based upon current service utilization data, it is anticipated that 38% of the target population will be indigent and uninsured and 60% will be covered by Medicaid.

Category 1 or 2 expected patient benefits: The project seeks to enroll and serve individuals with targeted complex needs with a baseline of 100 individuals in DY3 with a goal to increase to 125 served. In DY4 the goal will increase to serving 160 individuals. In DY5, 48 individuals (30%) receiving specialized interventions will demonstrate improved functional status.

Category 3 outcomes: IT 10.1. Our goal, Quality of Life. Our goal for improvement in quality of life will be determined in Year 4. This outcome goal will positively impact the need for appropriate diversion from expensive tertiary care, which has been shown to be temporary and not impacting on the cycle of super utilization.

Project Description:
The proposed project results from a collaborative planning effort among area hospitals and CHCS to identify and engage in treatment adults with significant unmet behavioral and physical health care needs who perpetually cycle through the community’s emergency departments (ED) and inpatient psychiatric facilities. This population will be most efficiently served, and will more likely recover, if their providers collaboratively plan for their needs. To this end, CHCS is developing protocols and a shared cloud-based data platform that will enable ED staff to quickly verify that a patient is a super-utilizer and gain access to the community treatment plan. If the individual has been lost from care, e.g., has not filled prescriptions or made recent therapy appointments, they will be reconnected to their treatment team before leaving the ED. Also, because all members of the target population have complex health concerns with a history of substantial reliance on acute and sub-acute care, CHCS will expand treatment to include a holistic perspective, including integrated primary and behavioral health care and clinical and organizational alignment with other community providers involved in care. The project will expand a current CHCS pilot that is developing a community collaborative response to identifying and providing effective interventions to high utilizers. Historically, there has not been a mechanism for cross-identification of these individuals between systems i.e., where else are they seeking care, and how providers have not worked together to deliver the care that is essential to helping these individuals attain stability and a higher level of functioning. The pilot project is limited in scope by funding; the proposed project will expand the numbers served, establish a framework for an effective, integrated community response and foster long-term sustainability of the intervention.

Project staff will be trained in the chronic care wellness and integrated care models to provide effective, evidence-based treatment to the patient population. Five licensed Behavioral Health Care Managers will be hired and trained for every 100 new consumers...
served. A psychiatric care provider (MD or APN) will be hired for every 200 new consumers served. An important attribute of the proposed project is that the comprehensive, community-based interventions it includes are patient-centered and in vivo, meeting the patient where he or she is in terms of clinical presentation, readiness for engagement and change, need, and physical location. Service selections will be based on the results of comprehensive psychosocial and multi-axial assessment and integrated treatment planning will include linkage to primary medical, mental health and substance abuse treatment services. A trauma informed service delivery system will be used and will feature evidence-based practices and tools. Additional supports will include transition services to help establish a stable living environment, peer support, specialized therapies, medical services, and residential options. The program will operate in the context of the recovery model in which the individual is encouraged and empowered to take an active role in his or her health and treatment, and is provided with tools and supports to achieve individual recovery goals, which will yield measurable improvement in quality of life. This approach has been found to be efficacious with the target population and is in direct response to a community-identified need for appropriate diversion from expensive tertiary care, which has been shown to be temporary and not impacting on the cycle of super utilization.

**Goals:** The goals are to: 1) avert negative outcomes, e.g., potentially avoidable psychiatric inpatient admission and readmissions, criminal justice involvement and homelessness; 2) break the cycle of overutilization of ED; 3) promote wellness and adherence to medication and other treatments; and 4) promote recovery in the community and enhanced quality of life.

**Challenges addressed by the project:** The target population consists of adults with severe mental illness and other factors -- e.g., chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement -- that produce an over-reliance on and over-utilization of emergency departments and psychiatric facilities. Targeted individuals are not reliably engaged in appropriate, effective or efficient behavioral or primary health care that will ensure their needs are met or that stability and community functioning is restored. In addition to experiencing sub-standard outcomes for their own health, their inappropriate over-utilization of acute and sub-acute care results in the diversion of health care dollars that could be more effectively deployed, exacerbating the health care resource deficit in Bexar County.

**5-year expected outcomes for CHCS.** 1) A comprehensive, collaborative continuum of care is established for the high utilizer population. 2) Scarce behavioral health care resources are more effectively utilized and cost of care is reduced. 3) Expanded access to psychiatric and related clinical services. 2) Increased engagement in care. 3) Reduced reliance upon crisis and emergency care. 4) Restoration of community functioning and quality of life.

**Recovery. Relation to Regional Goals.** Integrating all community care resources on behalf of the highest utilizing population is a key means of achieving the regional goal of “Improving the infrastructure for delivery of behavioral health services”. It also meets the CMS three part aim, as follows. The program fills an existing gap in care and **improves the existing behavioral health infrastructure** to better serve high utilizing adults in Bexar County. The program will support lasting community living and reduce hospital
re-admissions, which will **improve outcomes while containing cost growth.**

### Starting Point/Baseline:

The initial pilot project is funded for two years to serve a cohort of 50 individuals per year and to provide 60 intervention encounters per year per consumer. The proposed project will enable CHCS to serve an additional 50 super-utilizing consumers per year.

### Rationale:

The project option, 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population to include core components:

- **a)** Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
- **b)** Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.
- **c)** Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- **d)** Design models which include an appropriate range of community-based services and residential supports.
- **e)** Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Process Milestone P-2, Design community-based specialized interventions for target populations; and Improvement Milestone I-5, Functional Status, were selected in correspondence to an existing, unmet need for targeted interventions for super-utilizing adults with a complex constellation of unmet physical and behavioral health needs. The right place for these individuals to access specialized services is in community mental health settings. Attendant benefits include: a) positive impact on quality of life by ensuring consistent, appropriate treatment in the right setting; b) reduce inappropriate use of ED or in-patient psychiatric facilities; and, c) promote recovery and wellness with adherence to medication and other treatment modalities.

CHCS and the collaborating hospitals are conducting ongoing research and have identified multiple, evolving outcomes measures related to practice with this population from NAHQ, SAMHSA, Bureau of Primary Health Care, CMS. A Ph.D.-level external
evaluator has been hired to work with the partners on developing an evaluative framework that captures outcomes related to: reduction in system encounters, Quality of Life Measures, Self Efficacy, and general health measures aligned with NAHQ and the Bureau of Primary Health Care index of measures. The evaluation also will assess the impact of the intervention usage on standardized quantitative measures and qualitative analysis. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; and provider surveys. The collaborators will identify “lessons learned,” opportunities to scale all or part of the intervention to a broader patient population, and key challenges.

Waiver funding will expand the initial pilot project and add new community based services, e.g., transitional and supported housing and residential support programs, substance abuse treatment, and incentives for recovery. The project also will add peer support specialists to the intervention team. Participating consumers will have access to comprehensive screening, assessment, treatment planning and care. Behavioral Health Care Managers will provide evidence-based interventions and comprehensive coordination of services and will monitor service use for each patient over time to quantify impact. Performance assessment activities will examine the effect of participation on a specific set of high impact outcomes: 1) emergency room encounters, 2) crisis encounters, 3) psychiatric hospital encounters, and 4) criminal justice involvement. Data explorations will examine outcome variations for different racial/ethnic groups, and any cost benefits/effectiveness for implementing this treatment model.

The proposed project will positively addresses CN.4 - Inadequate mental health services results in avoidable costs to hospital and criminal and juvenile justice systems. More specifically, this project will address

- Inadequate access to care management and resource navigation.
- Inadequate services for individuals who have been arrested or incarcerated either as a result or precipitated by unmet behavioral health needs.
- Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders.
- Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments.

How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative: Significant enhancement.

Related initiatives funded by U.S. Department of HHS. None

### Related Category 3 Outcome Measure(s):

- **OD-10 Quality Of Life/ Functional Status.**
- **IT-10.1 Quality of life**

This measure is indicative of consumer retention in care and enhanced stability, both of which are critical means of reducing unnecessary hospitalizations and the inappropriate use of emergency departments.
**Relationship to other Projects:**
The proposed project will address significant behavioral health care resource insufficiency in Bexar County. As such, it is an integral component of this County’s health care infrastructure. Another proposed project seeks to establish research-based care for a segment of the population of adults with mental illness. These resources will be coordinated with the proposed project to build a more durable continuum of care.

**Relationship to Other Performing Providers’ Projects in the RHP:**
UTHSCA is proposing a potentially similar project. CHCS will join any collaborative learning communities with UTHSCA or other providers dedicated to serving adults with mental illness.

**Plan for Learning Collaborative:**
CHCS will participate in any and all relevant learning collaboratives organized by University Health System.

**Project Valuation:**
The value for this project is $1,602,595 for DY 2 and $7,186,790 for all years. By DY4, 160 adults who are high utilizers of behavioral health care will receive targeted, specialized support every year. The introduction of specialized, intensive care for adults with severe mental illness will ensure they are treated expeditiously, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public Health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served by the proposed program at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the
valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of specialized treatment for high utilizers of behavioral health care has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.2.4 PASS 2</th>
<th>2.13.1</th>
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<tr>
<td><strong>2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Coordinated Community Integrated Care Response for Super-Utilizing Consumers-Expand and Enhance Pilot Project</strong></td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
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<td>3.IT-10.1</td>
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<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
</tr>
<tr>
<td>Metric 1: P.2.1 Project plans which are based on evidence/experience and which address the project goals.</td>
<td>Metric 1: P.3.1. Number of targeted individuals enrolled/served in the project. Baseline: 100 Goal: 125 Data Source: Project records</td>
<td>Metric 1: P.3.1. Number of targeted individuals enrolled/served in the project. Goal: 160 Data Source: Project records</td>
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<td>Goal: Completion of plan. Data Source: Project documentation.</td>
<td>Milestone 2 Estimated Incentive Payment: $1,796,136</td>
<td>Milestone 3 Estimated Incentive Payment: $1,927,943</td>
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<td>Milestone 1 Estimated Incentive Payment: $1,602,595</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $1,602,595</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $7,186,790</td>
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**Identifying Project and Provider Information:**

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<tr>
<th>Title: 2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services: In House Women's Wellness Program (IHWWP)/Day Treatment</th>
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<td>Performing Provider: Center for Health Care Services</td>
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<td>Performing Provider TPI: 137251808</td>
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**Project Summary:**

**Provider Description:** Center for Health Care Services (CHCS) is the Local Mental Health Authority for Bexar County (population 1.75M). CHCS provides behavioral health services and treatment to children, adolescents and adults.

**Intervention(s):** CHCS seeks to establish a 24-bed comprehensive, safe, structured day treatment program and a therapeutic milieu living environment for females on the Haven for Hope campus, to be known as the In-House Women’s Wellness Program (IHWWP). The majority of consumers will have co-occurring mental health and/or substance use and chronic physical disorders; the program will support return of functioning by integrating and managing all aspects of their care, including offering single-site primary and behavioral health care. The carefully monitored therapeutic living environment will promote compliance with medication and treatment and greater physical and mental health stability. The ultimate goal will be for these highly vulnerable female consumers to enter into and maintain their recovery. Goal achievement will be advanced with the provision of psychosocial trauma focused treatment (Seeking Safety), a much-needed intervention given the prevalence of sexual violence the target population has experienced and the correspondingly high rate of Post-Traumatic Stress Disorder. IHWWP also will provide medication compliance using the Wellness Self-Management model.

**Need for the project:** CHCS has established an on-site psychiatric clinic and an In-House Wellness Program (IHWP) dormitory for males at Haven for Hope and both have exceeded service expectations and continue to grow in positive impact. However, there remains a critical need for similar, specialized residential services for females, most of whom have a complex constellation of physical and behavioral health care needs, issues of substance abuse and trauma, cognitive challenges, a lack of daily living skills, and minimal if any natural supports. While delivering the right care, at the right time and the right place is the right approach for all, current data reflects females (55%) are more likely to seek treatment if it is readily available than males (41%).

**Target population:** Homeless females with untreated physical and behavioral health disorders. These women can be expected to have significant, chronic physical and behavioral health problems and all will be extremely low income. Based upon current service information, 16% of the target population will be funded by Medicaid and 57% will be indigent and uninsured.

**Category 1 or 2 expected patient benefits:** The project seeks to improve functional status by 37 women (40%) in DY4, increasing to 51 women (55%) in DY5 with a baseline of 92 homeless women served in DY3.

**Category 3 outcomes:** IT-10.1. Our goal, to be quantified in DY4, is to improve quality of life.
Project Description:

CHCS seeks to establish a 24-bed comprehensive, safe, structured therapeutic living milieu for females at the Haven for Hope campus. The majority of residents will be transitioning from Prospects Courtyard (PCY) and will have co-occurring mental health and/or substance use and chronic physical disorders; the program will support their transition by integrating and managing all aspects of their care, including offering single-site primary and behavioral health care. The carefully monitored environment will promote compliance with medication and treatment and greater physical and mental health stability. The ultimate goal will be for these highly traumatized female consumers to obtain and maintain recovery.

CHCS, with funding from public and private stakeholders, has established an on-site psychiatric clinic and an In-House Men’s Wellness Program (IHWP) dormitory serving males; both of which have exceeded service expectations and continue to grow in utilization and positive impact. However, there remains a critical need for similar, specialized residential services for females, most of whom have a complex constellation of physical and behavioral health care needs, issues of substance abuse and trauma, cognitive challenges and a lack of daily living skills, and minimal if any natural supports. The new In-House Women's Wellness and day treatment Program (IHWWP) will address each of these presenting problems with the provision of psychosocial trauma focused treatment (Seeking Safety), a much-needed intervention given the prevalence of sexual violence the target population has experienced and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD). IHWWP also will provide medication compliance (Day Treatment) through evidenced-based practices, such as Wellness Self-Management (WSM). Core components will be provided or available, including residential assistance, psychosocial rehabilitation, supported employment, prescription medications, peer support, substance abuse services, and employment supports.

Goals. Improve health outcomes by delivering the right care at the right time and the right place. Increase use of preventive, primary and specialty care. Decrease use of costly ED and inpatient care.

Challenges addressed by the project. PCY, initially designed to accommodate 400 homeless adults (June 2010), has grown to sleeping more than 600 at night and caring for more than 800 during the day. PCY data shows that 30% of this population is female. Untreated physical and behavioral health problems are pervasive among the target population. As a result, Texans with severe and persistent mental illness were found to die 28 years sooner than the general population and the predominant causes of death were chronic illness, e.g., heart disease, lung disease, cancer. The most frequent causes of death for females were heart disease and stroke, both of which can be effectively addressed through integrated physical and behavioral health care. However, in the absence of easily accessed, integrated care, studies show that homeless persons routinely use hospital emergency departments (ED), a costly substitution and a major contributor to congestion and over-crowding in urban ED. Also, the primary means of transport to an ED for homeless persons is EMS and in 2011, the City of San Antonio’s EMS responded to 950 emergency calls at Haven for Hope, resulting in approximately 600 transports to area ED. Finally, while delivering the right care, at the right time and the right place is the right approach for all, current data reflects females (55%) are more likely to seek treatment, if readily available, than males (41%).
### 5-year expected outcomes for CHCS

1) Development of an integrated care management model oriented around the **female patient** that features accessible, integrated primary and behavioral health care. 2) Decreased inappropriate ED visits. 3) Decreased 911, psychiatric crisis and triage calls. 4) Decreased inappropriate utilization of EMS. 5) Decreased utilization of State and crisis transitional psychiatric beds. 6) Implementation of CQI activities as directed by the SAMHSA evidence-based toolkit for Permanent Supported Housing.

### 5-year expected outcomes for persons served by the project

1) Increased preventive physical health behaviors (e.g. vaccinations, nutrition, hygiene). 2) Improved overall primary, mental, and behavioral health outcomes. 3) Improved patient experience of care.

### Relation to Regional Goals

Psychiatric triage and primary care are available within two blocks of PCY but residents will not consistently utilize these resources. Therefore, the proposed project supports achievement of the regional goal of “Integrating behavioral health with physical health and other evidence-based services and supports”. The program also enables and ensures individualized, female **person-centered** care, filling a **gender gap** in care and **improving** the existing behavioral health infrastructure to better serve Medicaid and uninsured female adults.


### Starting Point/Baseline:

Integrated behavioral and physical health care is not currently available to the target population. The City of San Antonio’s EMS made over 600 transports to ED for all Haven for Hope residents. Also, while men have access to comprehensive, safe, structured, integrated care management (the CHCS-operated In House Men’s Wellness Program), **women do not**. This unacceptable, gender-based **health disparity** will be addressed by the In-House Women’s Wellness Program.

### Rationale:

The project option “Other” (2.13.2 Implement other evidence based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner), process milestone P2: Design community based specialized interventions for target population) and improvement milestone (I-5.1 % of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments) were selected in correspondence to an existing, unmet need for a comprehensive, safe, structured, integrated care management program for high-need, homeless females in Bexar County. The target population often has a complex combination of physical and behavioral health care needs combined with concomitant issues of substance abuse, traumatic injury, cognitive challenges and a lack of daily living skills and natural supports, causing them to be frequent users of public health services. This project will expand available treatment options (SS, WSM, and Matrix Psychosocial EBPs) for females and will establish a parallel, 24 bed dormitory (IHWWP) for females. Outcomes to be realized will include reductions in the inappropriate use of ED,
reductions in potentially avoidable inpatient admission and readmission, and promotion of recovery. CHCS has demonstrated the ability to improve functional status in this high need population through the existing, SAMHSA-funded Project HOMES, with outcomes that include significant functional improvement from baseline to 6 month follow-up.

The IHWWP addresses CN.4 – shortage of high quality mental and behavioral health services that are integrated with physical health care services and/or provide crisis stabilization.

More specifically it addresses:

- Need for integrated behavioral health and primary care services for homeless females
- Inadequate access to care management and resource navigation
- Inadequate resources for special needs populations (e.g., homeless adults, sex offenders) including efficiencies such as integrated behavioral and primary care, pharmacy services, telemedicine, and physician extenders
- Inadequate outpatient care for adults with moderate acuity behavioral health needs to support reductions in hospital readmissions and the inappropriate use of emergency departments

New initiative or significant enhancement of existing initiative. New initiative.

Related initiatives funded by U.S. Department of HHS. Other federal funding will not be used for this project. However as part of the continuum of housing and treatment services, clients being served in this proposed project are likely to benefit from other services offered by other separate programs that are funded by federal monies. CHCS recently received a Health Care Innovation grant from CMS to test and verify the efficacy of a specific integrated care model for the same target population. CHCS also received funding for Project HOMES, referenced above from the Substance Abuse and Mental Health Services Administration to serve the target population of high need homeless males and females.

**Related Category 3 Outcome Measure(s):**

The impact of the proposed primary and behavioral health care integration project can be measured by one stand-alone Category 3 Outcome Measure. 1) **OD-10 Quality of Life/Functional Status, IT-10.1 Quality of Life, IT-10-1a.** In a similar activity -- Project HOMES -- CHCS has already demonstrated statistically significant quality of life improvements using the SF-36 (IT-10-1b). Project HOMES will collaborate with the IHWWP to acquire permanent housing for the targeted population. **IT-10-1c.** Quality improvement will be monitored by SF-36 outcomes consisting of a pre-post single group design. The IHWWP target population also will be baselined and followed up at six (6) months.
**Relationship to other Projects:**

There are multiple projects proposed for RHP 6 that could support or be supported by the In-House Women’s Wellness Program, including increased training of the existing and additional peer workforce (1.2), implementation of a chronic disease registry (1.3), introduce, expand or enhance telemedicine/telehealth (1.7), and expand chronic care management models (2.2).

**Relationship to Other Performing Providers’ Projects in the RHP:**

There are no similar projects proposed for implementation in RHP 6. However, CHCS will participate in any relevant learning communities organized by University Health System.

**Plan for Learning Collaborative:**

CHCS will participate in any and all relevant learning collaborative organized by University Health System.

**Project Valuation:**

The value for this project for DY 2 is $1,006,831 and $4,369,746 for all years. By DY5, 92 homeless women with significant, chronic physical and behavioral health problems, many of which are exacerbated by lengthy histories of trauma, will receive day treatment and therapeutic milieu living services **every year**. The establishment of the In-House Women’s Wellness Program fills an existing gap in the local continuum of behavioral health care for high need female adults and frequent utilizers of public health care resources. The availability of this new resource will ensure homeless females receive the treatment they need in an easily accessed location with the capacity to meet needs in both health domains, and are stabilized, which will prevent or reduce costly, avoidable hospitalization and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach.

The annual value of benefits provided to those served at full implementation considered several factors in valuing this project such as reducing costs at hospitals, costs for emergency detention and use of psychiatric institutions. This information was based on extensive literature as well as a valuation study completed and prepared by professors of the Houston School of Public health and of the UT Austin Center for Social Work Research that was based on the cost utility model, usage of extensive literature of similar interventions, costs savings and health outcomes related to those interventions.

The annual value of benefits provided to those served by the In-House Women's Wellness Program at full implementation was calculated by multiplying the annual value of a single successful intervention by five. The rationale for selection of a multiplier of five was that to overcome resistance to change in a hard-to-serve population, both in the delivery and payment systems, five years of benefits would be needed. This assumption was verified as valid after an extensive literature review.

Cost-utility analysis (CUA) also was used to measure the cost of the program in dollars.
and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across different types of interventions, the common health goal, or outcome, is the number of life-years added.

The CUA calculations indicate that the availability of the In-House Women's Wellness Program has the potential to increase QALY among those it serves.
<table>
<thead>
<tr>
<th>137251808.2.5 PASS 2</th>
<th>2.13.2</th>
<th>N/A</th>
<th>2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services: In House Women's Wellness Program (IHWWP)/Day Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Health Care Services</td>
<td>TPI - 137251808</td>
<td>Quality of Life/Functional Status</td>
<td></td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>137251808.3.11</td>
<td>3.IT-10.1</td>
<td></td>
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</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
- P2: Design community based specialized interventions for target population.
- **Metric 1:** P2.1. Project plans which are based on evidence/experience and which address the project goals.
- **Goal:** A written project service delivery plan ready for implementation in DY3.
- **Data Source:** Written plan.
- **Milestone 1 Estimated Incentive Payment:** $1,006,831
- **Year 2 Estimated Milestone Bundle Amount:** $1,006,831

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 2**
- P2: Design community based specialized interventions for target population.
- **Metric 1:** P2.3.1-Number of targeted individuals enrolled and served in the project
- **Baseline:** No women are being served until DY3.
- **Goal:** 92 women served
- **Data Source:** HMIS census report
- **Milestone 2 Estimated Incentive Payment:** $1,081,226
- **Year 3 Estimated Milestone Bundle Amount:** $1,081,226

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 3**
- I-5: Functional Status
- **Metric 1:** I-5.1 – The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments
- **Goal:** 37 or 40% of baseline will demonstrate improvement in functional status
- **Data Source:** Standardized functional assessment instrument.
- **Milestone 3 Estimated Incentive Payment:** $1,161,011
- **Year 4 Estimated Milestone Bundle Amount:** $1,161,011

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 4**
- 1.5 Functional Status
- **Metric 1:** I-5.1 – The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments
- **Goal:** 51 or 55% of baseline will demonstrate improvement in functional status
- **Data Source:** Standardized functional assessment instrument.
- **Milestone 4 Estimated Incentive Payment:** $1,120,678
- **Year 5 Estimated Milestone Bundle Amount:** $1,120,678

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,369,746
<table>
<thead>
<tr>
<th><strong>Identifying Project and Provider Information:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mobile Crisis Outreach Teams</td>
</tr>
<tr>
<td><strong>Unique RHP ID#:</strong> 133340307.2.1 – PASS 1</td>
</tr>
<tr>
<td><strong>Provider Name:</strong> Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td><strong>TPI:</strong> 133340307</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Project Summary:</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Provider Description:</strong> Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.</td>
</tr>
<tr>
<td><strong>Intervention(s):</strong> This project will implement two Mobile Crisis Outreach Teams (one for Kerr and Gillespie counties and one for Val Verde County) to provide 24 hour a day, 7 day a week behavioral health crisis intervention and crisis follow up services within the community setting in order to reduce emergency department utilization, incarceration and hospitalizations.</td>
</tr>
<tr>
<td><strong>Need for the project:</strong> Between Gillespie, Kerr and Val Verde counties, Hill Country responded to 444 behavioral health crisis episodes between September 2011 and August 2012. Providing committed Mobile Crisis Outreach Teams transitions from screening for psychiatric hospitalization to providing community crisis services and supports aimed at helping the individual stabilize in the community.</td>
</tr>
<tr>
<td><strong>Target population:</strong> The target population is individuals within Gillespie, Kerr and Val Verde counties who have a behavioral health crisis. Between September 2011 and August 2012 this consisted of 444 individuals. Approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.</td>
</tr>
<tr>
<td><strong>Category 1 or 2 expected patient benefits:</strong> The project aims to establish two Mobile Crisis Outreach Teams which will have provided community based behavioral health crisis and crisis follow-up services to a minimum of 190 individuals within the community (30 in DY3; 60 in DY4 and .100 in DY5)</td>
</tr>
</tbody>
</table>
| **Category 3 outcomes:** IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Mobile Crisis Outreach Teams showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department utilization and incarceration.
**Project Description:**

Hill Country MHDD Centers does not currently have Mobile Crisis Outreach Teams within the eleven counties served by Hill Country from Regional Health Plan 6. Mobile Crisis Outreach Team services are would be available 24 hours/day, 7 days per week. According to *Evaluation Findings for the Crisis Services Redesign Initiative* published by Texas A&M University in January 2010, the development of Mobile Crisis Outreach Teams moves the focus from screening individuals for state hospitalization to considering other intervention strategies tailored to the needs of the particular situation thus increasing the likelihood that crises can be resolved in the community. Mobile Crisis Outreach Team (MCOT) activities include Crisis Assessment, Treatment Placement, and Preventive Crisis Support Services. MCOT staff not only help resolve crisis episodes, they also help recovering consumers regain stability and resiliency to avoid relapse by providing temporary supports, providing support and care for individuals in eminent danger of or following a crisis, and provide follow-up care for consumers recently released from a psychiatric hospital. Mobile Crisis Outreach Teams typically are comprised of a combination of Qualified Mental Health Professionals, Licensed Practitioners of the Healing Arts, psychiatrists, and nurses.

Hill Country MHDD Centers is planning to implement two Mobile Crisis Outreach Teams. Based on the number of consumers who had crisis calls during fiscal year 2012, one Mobile Crisis Outreach Team would be serve Gillespie and Kerr counties where 315 individuals had crisis episodes during the last year and one would serve Val Verde County along the Texas Mexico border where 129 individuals had crisis episodes during the last fiscal year.

**Challenges:**

The primary challenge for implementation of the project is recruiting behavioral health staff available on a 24 hour basis. Hill Country will address the challenge by offering incentive, if necessary, and utilizing Psychiatrists for consultation for the Mobile Crisis personnel through telephone and telemedicine.

**Goals:**

The goal of this project is to establish alternatives to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for individuals in psychiatric crisis. By the end of five years, Hill Country will have established two additional Mobile Crisis Outreach Teams which will have provided services to a minimum of 190 consumers within the community (30 in DY3; 60 in DY4 and 100 in DY5).

**Relationship to the Regional Goals:**

The goal of this project is to use Mobile Crisis Outreach Teams to provide behavioral health crisis services, wrap around and follow up services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way. In addition, the establishment of the Mobile Crisis Outreach Teams will help achieve the regional goal to improve the health care infrastructure to better serve the Medicaid and uninsured residents of Gillespie, Kerr and Val Verde counties.
Starting Point/Baseline:
Hill Country MHDD Centers currently operates a Mobile Crisis Outreach Team in Hays County which is outside of Regional Healthcare Partnership 6. Hill Country will utilize the experience and lessons learned from operation of the Hays County Mobile Crisis Outreach Team to establish two Mobile Crisis Outreach Teams in Regional Healthcare Partnership 6. The Hays County Mobile Crisis Outreach Team served 228 consumers during the most recent fiscal year. Hill Country MHDD Centers currently does not operate a Mobile Crisis Outreach Team within Regional Health Partnership 6. Therefore, the baseline number of participants begins at 0 in DY2.

Rationale:
Hill Country MHDD Centers is planning to implement two Mobile Crisis Outreach Teams. Based on the number of consumers who had crisis calls during fiscal year 2012, one Mobile Crisis Outreach Team would be serve Gillespie and Kerr counties where 315 individuals had crisis episodes during the last year and one would serve Val Verde County along the Texas Mexico border where 129 individuals had crisis episodes during the last fiscal year. Mobile Crisis Outreach Teams are designed to avoid psychiatric hospitalization whenever possible by providing services within the community.

Mobile Crisis Outreach Team (MCOT) activities include Crisis Assessment, Treatment Placement, and Preventive Crisis Support Services. MCOT staff not only help resolve crisis episodes, they also help recovering consumers regain stability and resiliency to avoid relapse by providing temporary supports, providing support and care for individuals in eminent danger of or following a crisis, and provide follow-up care for consumers recently released from a psychiatric hospital. Mobile Crisis Outreach Teams typically are comprised of a combination of Qualified Mental Health Professionals, Licensed Practitioners of the Healing Arts, psychiatrists, and nurses.

Project Components:
Through the Mobile Crisis Outreach Teams, Hill Country MHDD Centers proposes to meet all required project components:

A) Assess size, characteristics and needs of target population. Hill Country will collect and analyze information on individuals who have a behavioral health crisis and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to crisis episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for Mobile Crisis Outreach Teams.

B) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals in behavioral health crisis in order to provide targeted training for staff and to develop innovative wrap around services to help avert future crisis episodes.
C) **Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.** Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the crisis, the services received, the number of individuals receiving follow up services after the crisis episode, the number of individuals with recurring crisis episodes, and progression on the Activities of Daily Living assessment.

D) **Design models which include an appropriate range of community-based services and residential supports.** Based on the size, characteristics and needs for the target population, Hill Country will train Mobile Crisis Outreach Team staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) **Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.** Hill Country will utilize the Activities of Daily Living assessment to determine progression of individuals receiving Mobile Crisis Outreach Team services. In addition, Hill Country will do follow up surveys with individuals who receive Mobile Crisis Outreach Team services to determine satisfaction with services and to help ensure stabilization of symptoms in order to avert additional crisis episodes.

Unique community need identification number the project addresses:
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country does not have a Mobile Crisis Outreach Team within Regional Healthcare Partnership 6. Through funding provided by the Texas Department of State Health Services, Hill Country provides a Crisis Hotline certified by the American Association of Suicidology and sends Qualified Mental Health Professionals to address the immediate needs of the crisis and determine if the individual is appropriate for psychiatric hospitalization. The addition of the Mobile Crisis Outreach Teams would give committed staff to providing ongoing crisis services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis.

**Related Category 3 Outcome Measure(s):**

OD-10 Quality of Life/Functional Status  
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:
Mobile Crisis Outreach Team service impacts an individual’s mental health and thus their quality of life.
of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future services and discharge.

The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

**Relationship to other Projects:**
Provision of Mobile Crisis Outreach Team services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (1333340307.2.2 Psychiatric Consultation, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, and 133340307.2.4 Trauma Informed Care) by providing specialized services addressing crisis episodes and aimed at averting reoccurrence of crisis episodes experienced by an individual that if not addressed in the community may result in needing inpatient psychiatric services. Addressing the crisis episode in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

**Relationship to Other Performing Providers’ Projects in the RHP:**
Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.
### Plan for Learning Collaborative:

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

### Project Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 190 consumers over the life of the project resulting in a valuation overall of $15,642 per individual served.
| 133340307.2.1  
PASS 1 | 2.13.1 | 2.13.1 A-E | 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mobile Crisis Outreach Teams |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
<td>TPI - 133340307</td>
<td>Activities of Daily Living</td>
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<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133340307.3.1</th>
<th>3.IT-10.2</th>
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**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1**
P-2: Design community-based specialized intervention for target population

**Metric 1 P-2.1:** Project plans based on evidence/experience and which address the project goals

- **Baseline:** No intervention has been designed
- **Goal:** Submission of project plan
- **Data Source:** Project documentation

**Milestone 1 Estimated Incentive Payment:** $626,102

**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 2**

- **1-X:** Number of individuals beginning service during demonstration year

**Metric 1 1-X.1:** Number of targeted individuals beginning services during demonstration year (Mobile Crisis Outreach Teams)

- **Baseline/Goal:** Baseline - 0 individuals served; Goal - 30 individuals beginning service during DY3

**Data Source:** Hill Country MHDD records/EHR

**Milestone 2 Estimated Incentive Payment:** $653,159

**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 3**
P-4: Evaluate and continuously improve interventions

**Metric 1 P4.1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

- **Baseline:** No evidence of improvement initiatives
- **Goal:** Documentation of how monthly real-time data is used to guide continuous quality improvement

**Data Source:** Hill Country MHDD records

**Milestone 3 Estimated Incentive Payment:** $329,955

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 5**
P-4: Evaluate and continuously improve interventions

**Metric 1 P4.1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

- **Baseline:** DY4 improvement initiatives
- **Goal:** Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement

**Data Source:** Hill Country MHDD records

**Milestone 5 Estimated Incentive Payment:** $337,550
<table>
<thead>
<tr>
<th>Milestone 4</th>
<th>Milestone 6</th>
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<tbody>
<tr>
<td>[I-X]: Number of individuals beginning service during demonstration year&lt;br&gt;Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mobile Crisis Outreach Teams)&lt;br&gt;Baseline/Goal: Baseline - 0 individuals beginning service in DY2; Goal - 60 individuals beginning service during DY4 (for a total of 90)&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Milestone 4 Estimated Incentive Payment: $329,955</td>
<td>[I-X]: Number of individuals beginning service during demonstration year&lt;br&gt;Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mobile Crisis Outreach Teams)&lt;br&gt;Baseline/Goal: Baseline - 0 individuals beginning service in DY2; Goal - 100 individuals beginning service during DY5 (for a total of 190)&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Milestone 6 Estimated Incentive Payment: $337,550</td>
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</table>

| Year 2 Estimated Milestone Bundle Amount: $626,102 | Year 3 Estimated Milestone Bundle Amount: $653,159 | Year 4 Estimated Milestone Bundle Amount: $659,910 | Year 5 Estimated Milestone Bundle Amount: $675,100 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,614,271**
**Identifying Project and Provider Information:**

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<tr>
<th>Title</th>
<th>2.16.1 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hill Country Virtual Psychiatric and Clinical Guidance</th>
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<tbody>
<tr>
<td>Unique RHP ID#</td>
<td>133340307.2.2 – PASS 1</td>
</tr>
<tr>
<td>Provider Name</td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI</td>
<td>133340307</td>
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</table>

**Project Summary:**

<table>
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<tr>
<th>Provider Description</th>
<th>Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention(s)</td>
<td>This project will implement psychiatric and clinical guidance 24 hour a day, 7 day a week for primary care physicians and hospitals within the 11 counties served by Hill Country in RHP6 in order to help physicians identify and treat behavioral health symptoms earlier in order to avoid exacerbation of symptoms into a behavioral health crisis.</td>
</tr>
<tr>
<td>Need for the project</td>
<td>In meetings with the six general hospitals throughout Hill Country’s service area in RHP6, the hospitals noted that one of the greatest needs for their doctors is psychiatric consultation. In addition, ten of the eleven counties served by Hill Country in RHP6 are designated as Entire County Healthcare Provider Shortage Areas for Mental Health.</td>
</tr>
<tr>
<td>Target population</td>
<td>The target population is individuals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties who demonstrate behavioral health symptoms and seek treatment at area hospitals or with their primary care physician. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.</td>
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<tr>
<td>Category 1 or 2 expected patient benefits</td>
<td>The project aims to establish psychiatric and clinical guidance 24 hours a day, 7 days a week for primary care physicians and hospitals with the 11 counties served by Hill Country in RHP6 which will provide psychiatric consultation and clinical guidance to primary care physicians and hospitals in order to identify behavioral health symptoms and to begin treatment as soon as possible. The project seeks to provide 4,000 psychiatric consultations by the end of DY5 (500 during DY3; 1,500 during DY4; and 2,000 during DY5) for the 11 counties served by Hill Country in RHP6.</td>
</tr>
</tbody>
</table>
| Category 3 outcomes | IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) 5% of population between 12 and 18 years of age have had PHQ-A or BDI-PC screening performed in order to identify symptoms and treat adolescents with symptoms of depression. IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9) 5% of population over
18 years of age have had PHQ-9 screening performed in order to identify symptoms and treat adults with symptoms of depression

IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE/AUDIT) 5% of population over 18 years of age have had a CAGE or AUDIT screening performed in order to identify symptoms and treat adults with substance use disorder

**Project Description:**

According to *Mental Health Care by Family Physicians*, a paper prepared by the American Academy of Family Physicians, “Mental health issues are frequently unrecognized and even when diagnosed are often not treated adequately. Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. In a recent national survey of mental health care, 18% of the surveyed population with and without a DSM-IV diagnosis of a mental health disorder sought treatment during a 12 month period, with 52% of those visits occurring in the general medical (all primary care) sector. Estimates are that 11% to 36% of primary care patients have a psychiatric disorder, with one recent survey of mental health conditions in urban family medicine practices revealing that over 40% of survey respondents met criteria for a mental health disorder.”

Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. Due to ten of the eleven counties served by Hill Country MHDD Centers being designated as Mental Health Professional Shortage areas, there is a need to develop Psychiatric Consultation services and have them available for Primary Care Physicians and hospitals throughout the region to assist with complex psychiatric needs.

**Challenges:**
The greatest challenge of the project will be recruitment of necessary personnel due to being Mental Health Professional Shortage areas. Hill Country will address the challenge by offering incentives as necessary.

**Goals:**
The goal of this project is to provide PCPs and hospitals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions through Psychiatric Consultation. By the end of five years, Hill Country MHDD Centers will have an established psychiatric consultation service available for all primary care providers and hospitals within the eleven counties with at least fifty providers enrolled and a minimum of twenty percent of primary care physicians within the counties utilizing the service will be satisfied with the psychiatric consultation provided for patients in their care. Overall, the availability of Psychiatric Consultation should result in earlier identification and treatment of mental health issues and increase integration of services for individuals seeking psychiatric assistance in the primary care setting.

**Relationship to Regional Goals:**
The goal of this project is to establish Virtual Psychiatric and Clinical Guidance to Primary Care Physicians and Hospitals. By providing Virtual Psychiatric and Clinical Guidance in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing...
patients high-quality and patient-centered care, in the most cost effective way. In addition, providing consultation and guidance to primary care physicians further develops and maintains a coordinated care delivery system.

### Starting Point/Baseline:

There are currently no dedicated resources for behavioral health consultation available to hospitals and primary care physicians within the eleven counties served by Hill Country within RHP 6. No formal structure currently exists for primary care physicians and hospitals to obtain clinical guidance regarding patients presenting with behavioral health issues.

### Rationale:

Hill Country MHDD Centers serves eleven counties (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde) within Regional Healthcare Partnership 6. Ten of the eleven counties served by Hill Country MHDD Centers are designated as Entire County Healthcare Provider Shortage Areas for Mental Health (Bandera, Comal, Edwards, Gillespie, Kerr, Kinney, Medina, Real, Uvalde and Val Verde) As such, resources for psychiatric and clinical guidance to primary care providers delivering services to behavioral health patients is very limited and not formalized throughout the area.

The eleven counties served by Hill Country MHDD within RHP6 have a total population of 401,123 in 2012. Within the eleven counties, there are six general hospitals (CHRISTUS Santa Rosa New Braunfels, Hill Country Memorial, Peterson Regional Medical Center, Medina Regional Hospital, Uvalde Memorial Hospital, and Val Verde Regional Medical Center) and there are three hundred thirty-four physicians with their primary practice location listed in the area. Of these three hundred thirty-four physicians, ninety-five have their specialty listed as Family Practice or General Practice.

### Project Components:

As a formal structure for psychiatric consultation for primary care physicians and hospitals does not exist within the eleven counties, Hill Country MHDD Centers proposes to meet all required project components:

- **A) Establish the infrastructure and clinical expertise to provide remote psychiatric consultative services.** Hill Country will review and improve telecommunication equipment based on estimated volume of services and recruit appropriate clinical staff with the clinical expertise to provide remote psychiatric consultative services.

- **B) Determine the location of primary care settings with a high number of individuals with behavioral health disorders (mental health and substance abuse) presenting for services, and where ready access to behavioral health expertise is lacking. Identify what expertise primary care providers lack and what they identify as their greatest needs for psychiatric and/or substance abuse treatment consultation via survey or other means.** Hill Country will survey area hospitals and primary care physicians to determine the potential volume of consultation needed as well as the primary types of issues where consultation is needed. The survey will include areas of needed consultation, estimated of occurrences for consultation, as well as the means by which the primary care physician wishes to receive consultation.
C) Assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models. Based on feedback from primary care physicians and hospitals, Hill Country will review successful models of psychiatric consultation and assess the models for applicability to the region being served to determine the most appropriate methods to implement.

D) Build the infrastructure needed to connect providers to virtual behavioral health consultation. Hill Country will review current telecommunication capacity and improve telecommunication and telemedicine equipment based on estimated volume of services and connections needed to perform consultation efficiently and effectively based on the volume of services estimated and the model of consultation being provided. Hill Country will also develop staffing patterns and acquire all necessary personnel to ensure appropriate clinical expertise is available for consultation regarding both adult and children’s mental health needs.

E) Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24-hour basis. Hill Country will staff the program for 24 hour a day coverage, will survey hospitals and primary care physicians to ensure clinical guidance is available 24 hours a day as needed, and conduct random mystery calls for clinical guidance to ensure 24 hour virtual psychiatric consultative services are available.

F) Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation. Based on the recommended model of implementation for the service area and feedback from primary care physicians, area hospitals and other medical providers, Hill Country will conduct needs assessments to determine which primary care settings could benefit from remote psychiatric consultation.

G) Provide outreach to medical disciplines in primary care settings that are in need of telephonic behavioral health expertise and communicate a clear protocol on how to access these services. Based on needs assessments and survey, Hill Country will develop protocol and enter memorandums of understanding which define a clear protocol on how to access the remote psychiatric consultation.

H) Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation. Hill Country will add necessary service codes and modifiers to the EHR and other tracking documents within the agency to track all activity of the telephonic behavioral health consultation.

I) Develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services. Hill Country will formalize procedures for collecting and reporting on activities associated with remotely delivered behavioral health consultative services.

J) Review the intervention(s) impact on access to telephonic psychiatric consults and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. Hill Country will continually review with primary care providers how the service has supported their practice, ways to improve the service, and how to expand the service to additional providers.

Unique community need identification number the project addresses:
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

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

There are currently no Virtual Psychiatric Consultation services available within the counties served by Hill Country in RHP.

**Related Category 3 Outcome Measure(s):**

**OD-12 Primary Care and Primary Prevention**

**IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)**

The number of PHQ-A/BDI-PC performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the 12 to 18 year population of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates.

**IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)**

The number of PHQ-9 performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates.

**IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)**

The number of CAGE/AUDIT performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates.

Reasons/rationale for selecting the outcome measure:
The screening instruments above were selected as a method for primary care providers to identify issues that may require virtual psychiatric consultation. By performing the instruments, early diagnosis and intervention of potential symptoms may be addressed in order to avoid escalation of symptoms into a crisis episode.

**Relationship to other Projects:**

Provision of Virtual Psychiatric Consultation services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, and 133340307.2.4 Trauma Informed Care) by providing specialized consultative services addressing behavioral health issues before they become a crisis. Addressing the behavioral health issues in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).
**Relationship to Other Performing Providers’ Projects in the RHP:**

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on an estimated 4,000 consultations for individual patients over the life of the project (500 during DY3; 1,500 during DY4; and 2,000 during DY5) resulting in a valuation per patient of $1,486.04.
<table>
<thead>
<tr>
<th>133340307.2.2</th>
<th>2.16.1</th>
<th>2.16.1 A-J</th>
<th>2.16.1 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hill Country Virtual Psychiatric and Clinical Guidance</th>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>133340307.3.2</td>
<td>3.IT-12.5</td>
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<td>Other USPSTF-endorsed screening outcome measures (PHQ-9)</td>
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<td>133340307.3.4</td>
<td>3.IT-12.5</td>
<td>Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</table>

**Milestone 1**

P-2: Design psychiatric consultation services that would allow medical professionals in primary care settings to access professional behavioral health expertise (via methods such as telephone, instant messaging, video conference, facsimile, and email)

**Metric 1 P-2.1:**
- Baseline: No intervention has been designed
- Goal: Submission of project plan
- Data Source: Project documentation

**Milestone 2**

P-3: Enroll primary care settings into the remote behavioral health consultation services

**Metric 1 P-3.1:** Number of PCP settings that use psychiatric consultative services
- Baseline: 0 providers enrolled
- Goal: Enroll 30 providers
- Data Source: Signed enrollment agreements

**Milestone 3**

P-4: Determine the impact of the project

**Metric 1 P-4.1:** Develop

**Milestone 4**

P-5: Evaluate and continuously improve psychiatric consultative services

**Metric 1 P-5.1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
- Baseline: DY 4 Process initiative
- Goal: Documentation of data analysis and how data was utilized to improve service delivery at least 6 times during the year
- Data Source: Project reports include documentation of how real-time data was used for rapid-cycle improvement to guide continuous quality
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<td>Milestone 7</td>
<td>$675,101</td>
</tr>
<tr>
<td>Milestone 8</td>
<td>$675,100</td>
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</table>

**Evaluation Plan**

- **Evaluation Plan Including Metrics, Operation and Evaluation Protocols**
  - **Baseline:** No intervention has been designed
  - **Goal:** Develop formal plan for Quality and Utilization Management of project including development of clinical code modifiers and data collection as well as satisfaction of physicians receiving consultation services

- **Data Source:** Project documentation including formal plan for Quality and Utilization Management of project including development of clinical code modifiers and data collection as well as satisfaction of physicians receiving consultation services

**Metric 1 P-5.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles**

- **Baseline:** No intervention has been designed
- **Goal:** Documentation of data analysis and how data was utilized to improve service delivery at least 6 times during the year
- **Data Source:** Project reports include documentation of how real-time data was used for rapid-cycle improvement to guide continuous quality improvement

**Milestone 5 Estimated Incentive Payment:** $439,940

**Milestone 7 Estimated Incentive Payment:** $675,101

**Milestone 8**

- **Metric 1 [I-X.1]: Number of targeted individuals receiving psychiatric consultation**

**Milestone 8 Estimated Incentive Payment:** $675,100
DY3; Goal – 1,500 individuals/patients receiving psychiatric consultation during DY4;  
Data Source: Hill Country MHDD records/EHR  
Milestone 6 Estimated Incentive Payment: $439,941

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<td>$1,350,201</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $5,228,544
Identifying Project and Provider Information:

Title: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder

Unique RHP ID#: 133340307.2.3 - PASS 1

Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

TPI: 133340307

Project Summary:

Provider Description: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.

Intervention(s): This project will implement Co-occurring Psychiatric and Substance Use Disorder Services within the 11 counties served by Hill Country in RHP6 in order to meet the needs of individuals with psychiatric and substance use issues within the community setting in order to reduce emergency department utilization, inpatient utilization, and incarceration.

Need for the project: Of the 4,490 individuals receiving mental health services through Hill Country in RHP6, 924 report substance use while 351 report substance use at a level that interferes with their daily lives and/or medications. In meeting with area hospitals, individuals with psychiatric disorders who also abuse substances end up in their emergency departments.

Target population: The target population is individuals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties who have a psychiatric diagnosis and abuse substances. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project aims to establish Co-occurring Psychiatric and Substance Use Disorder services within the 11 counties served by Hill Country in RHP6 which will provide psychiatric and substance use disorder services within the community setting in order to reduce emergency department utilization and incarceration. The project seeks to provide services to a minimum of 234 individuals entering service from the 11 counties served by Hill Country in RHP6 by the end of DY5 (new enrollees 50 in DY3; 84 in DY4; and 100 in DY5).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Co-occurring Psychiatric and Substance Use Disorder services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department utilization and incarceration.
Project Description:
According to SAMHSA statistics on co-occurring disorders, 25.7 percent of all adults with serious mental illness also suffer from substance use dependence and 19.7 percent of adults with any mental illness also suffer from substance use dependence. Hill Country currently serves over 4,490 adults with Severe and Persistent Mental Illness on an annual basis within eleven counties of RHP 6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Of the 4,490 individuals served, 924 report substance use while 351 report substance use at a level that interferes with their daily lives and/or medication. Throughout the 22,000 square mile service delivery area of Hill Country MHDD Centers, there is one individual dedicated to Co-occurring service delivery. By expanding this service, Hill Country can better address the need of individuals with co-occurring psychiatric and substance use disorder.

Hill Country MHDD Centers is planning to add Co-occurring Psychiatric and Substance Use Disorder services throughout the eleven county area served by Hill Country in RHP6. Hill Country currently serves over 4,490 adults with Severe and Persistent Mental Illness on an annual basis within eleven counties of RHP 6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Of the 4,490 individuals served, 924 report substance use while 351 report substance use at a level that interferes with their daily lives and/or medication. Throughout the 22,000 square mile service delivery area of Hill Country MHDD Centers, there is one individual dedicated to Co-occurring service delivery.

Challenges:
The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

Goals:
The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services throughout the eleven county area in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population. By the end of five years, Hill Country will have established Co-occurring Psychiatric and Substance Use Disorder specialists which will have provided services to a minimum of 234 consumers within the community over the life of the project (new enrollees 50 in DY3; 84 in DY4; and 100 in DY5).

Relationship to the Regional Goals:
The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way. In addition, the establishment of Co-occurring Psychiatric and Substance Use Disorder services will help achieve the regional goal to improve the health care infrastructure to better serve the Medicaid and uninsured residents of the eleven counties served by Hill Country in RHP6.
Starting Point/Baseline:
Hill Country MHDD Centers currently has one individual specializing in delivering Co-occurring Psychiatric and Substance Use Disorder services who serves forty individuals on an annual basis. This project will expand the service to all 11 counties served by Hill Country in RHP6.

Rationale:
Hill Country will identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual

Project Components:
Through the Co-occurring Psychiatric and Substance Use Disorder services, Hill Country MHDD Centers proposes to meet all required project components:

A. **Assess size, characteristics and needs of target population.** Hill Country will collect and analyze information on individuals who have co-occurring psychiatric and substance use disorder and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.

B. **Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.** Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals co-occurring psychiatric and substance use disorder in order to provide targeted training for staff. Primary concentration will be based on SAMSHA’s Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices Kit.

C. **Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.** Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment.

D. **Design models which include an appropriate range of community-based services and residential supports.** Based on the size, characteristics and needs for the target population, Hill Country will train Co-occurring Psychiatric and Substance Use Disorder specialists in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E. **Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.** Hill Country will utilize the Activities of Daily Living assessment to determine progression of individuals receiving Co-occurring...
Psychiatric and Substance Use Disorder services. In addition, Hill Country will do follow up surveys with individuals who receive services to determine satisfaction with services and to help ensure stabilization of symptoms.

Unique community need identification number the project addresses:
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country MHDD Centers currently has one individual specializing in delivering Co-occurring Psychiatric and Substance Use Disorder services who serves forty individuals on an annual basis. This individual is funded through the Texas Department of State Health Services contract which includes federal and state funds. This project will expand the service to all 11 counties served by Hill Country in RHP6.

**Related Category 3 Outcome Measure(s):**

- OD-10 Quality of Life/Functional Status
- IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:
Co-occurring Psychiatric and Substance Use Disorder impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.
### Relationship to other Projects:
Provision of Mobile Crisis Outreach Team services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 133340307.2.2 Psychiatric Consultation, and 133340307.2.4 Trauma Informed Care) by providing specialized services addressing Co-occurring Psychiatric and Substance Use Disorder for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

### Relationship to Other Performing Providers’ Projects in the RHP:
Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde, and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

### Plan for Learning Collaborative:
Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

### Project Valuation:
Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 234 consumers over the life of the project resulting in an overall value of $19,054 per individual served.
## 2.13.1 A-E

**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder**

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<th>Milestone</th>
<th>Description</th>
<th>Baseline</th>
<th>Goal</th>
<th>Data Source</th>
<th>Milestone Estimated Incentive Payment</th>
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<tbody>
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<td>Milestone 1</td>
<td>P-2: Design community-based specialized intervention for target population</td>
<td>Program is currently only available in Kerr and Gillespie counties</td>
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<td></td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,921,410**
Identifying Project and Provider Information:

Title: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care
Unique RHP ID#: 133340307.2.4 – PASS 1
Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
TPI: 133340307

Project Summary:

Provider Description: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.

Intervention(s): This project will implement Trauma Informed Care Services within the 11 counties served by Hill Country in RHP6 in order to meet the needs of individuals who have experienced trauma that is impacting their behavioral health. The project will incorporate community education on the impact of trauma through Mental Health First Aid training and Trauma Informed Care training, and will provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.

Need for the project: Studies have shown that the majority of individuals who are incarcerated have suffered traumatic experiences and that individuals who suffer traumatic experiences are 300% more likely to develop ischemic heart disease. By treating trauma, individuals address the trauma in their life and reduce the chance of internalizing the trauma resulting in physical illnesses, a behavioral health crisis, or in reactions that may result in incarceration.

Target population: The target population is individuals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties who have suffered trauma. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project aims to establish Trauma Informed Care within the 11 counties served by Hill Country in RHP6. Trauma Informed Care will provide community education on identifying trauma symptoms and treatment for individuals who have suffered from trauma in an effort to identify trauma symptoms early and begin treatment to avoid emergency department utilization and incarceration. The project seeks to provide services to a minimum of 200 individuals from the 11 counties served by Hill Country in RHP6 by the end of DY5 (number anticipated beginning service by year, DY3 40; DY4 60; DY5 100).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Trauma Informed Care showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department
utilization and incarceration.

**Project Description:**

According to Dr. Eric Kandel’s New Intellectual Framework for Psychology, studies show that medication doesn’t change molecular structure of the brain – experiences do. When an individual is exposed to trauma over long periods, it drastically effects their mental health. Further research indicates that many children diagnosed with ADD and ADHD are actually suffering from trauma and PTSD. In the article *Diagnosis: ADHS – or Is It Trauma?*, it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences.

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. In the July-Sept. 2012 Youth Law New, *Trauma-Informed Care Emerging as Proven Treatment for Children, Adults with Behavioral, Mental Health Problems*, states, “Children who are physically or sexually abused, or who go through other trauma-inducing experiences can develop mental health disorders and related problems. Indeed, trauma can fundamentally affect how a young person grows and develops.” According to a study cited in *Trauma among Girls in the Juvenile Justice System*, A person traumatized in childhood may resort to criminal behavior. When a survey of all juvenile detainees nationwide, 93.2% per cent of males and 84% of females reported having had a traumatic experience. In Kaiser’s Adverse Childhood Experiences (ACE) study researchers looked at patients with ACE scores of 7 or higher who didn’t smoke, didn’t drink to excess, and weren’t overweight. The study revealed that the risk of ischemic heart disease (the most common cause of death in the United States) was 360 percent higher than for patients who scored a 0 on the ACE. (Paul Tough, “The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult?”, The New Yorker, March 21, 2011).

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The National Center for Trauma Informed Care, a division of SAMHSA, facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support.

**Challenges:**

The primary challenge for implementation of the project is recruiting behavioral health staff. Hill Country will address the challenge by offering incentive as necessary.
Goals:
The goal of this project is to establish Trauma Informed Care throughout the eleven counties served by Hill Country in RHP6. The project will consist of developing Healthy Communities through the use of Mental Health First Aid Training and Trauma Informed Care training as a means to help the community understand the impact of trauma and to help identify symptoms of trauma for earlier treatment. In addition, a system of trauma counseling will be developed including practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced. The primary challenge of the project will be recruitment and training of staff for initial implementation. By the end of five years, Hill Country’s goal is to have trained at least 500 individuals in Mental Health First Aid and/or Trauma Informed Care and will have established Trauma Informed Care throughout the eleven county service area and provided services to at least of 200 consumers within the community over the life of the project (number anticipated beginning service by year, DY3 40; DY4 60; DY5 100).

Relationship to the Regional Goals:
The goal of this project is to provide Trauma Informed Care within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way. In addition, the establishment of the Trauma Informed Care will help achieve the regional goal to improve the health care infrastructure to better serve the Medicaid and uninsured residents the counties Hill Country serves within the region.

Starting Point/Baseline:
Hill Country MHDD Centers currently provides Cognitive Behavioral Therapy to individuals suffering from Major Depression and Cognitive Processing Therapy for individuals who have experienced a crisis episode and suffer from Post Traumatic Stress Disorder. During fiscal year 2011, Hill Country MHDD Centers provided 1050 hours of Cognitive Behavioral Therapy and Cognitive Processing Therapy combined. This program would enable Hill Country to acquire and train additional clinicians to provide Cognitive Behavioral Therapy and Cognitive Processing Therapy to a broader population at an earlier stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments, potential psychiatric hospitalizations and utilization of the criminal justice system.

Rationale:
The approach Hill Country will take with this project will include building health communities by offering Mental Health First Aid Training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations. The training will be aimed at helping individuals understand the role trauma plays in their lives and helping identify early warning signs of mental health issues. In addition, Hill Country will design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.

Project Components:
Through the Trauma Informed Care services, Hill Country MHDD Centers proposes to meet all required project components:
A. **Assess size, characteristics and needs of target population.** Hill Country will collect and analyze information on individuals who have issues due to an experienced trauma and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to trauma in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.

B. **Review literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes/quality of life.** Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals in Trauma Informed Care in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the trauma.

C. **Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.** Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living assessment.

D. **Design models which include an appropriate range of community-based services and residential supports.** Based on the size, characteristics and needs for the target population, Hill Country will train Trauma Informed staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E. **Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.** Hill Country will utilize the Activities of Daily Living assessment to determine progression of individuals receiving Trauma Informed Care. In addition, Hill Country will do follow up surveys with individuals who receive Trauma Informed Care services to determine satisfaction with services and to help ensure stabilization of symptoms in order to avert additional recurrence of trauma symptoms.

Unique community need identification number the project addresses:
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical health and/or provide crisis stabilization.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country does not currently have a Trauma Informed Care initiative within Regional Healthcare Partnership 6. The addition of the Trauma Informed Care would give committed
staff to providing ongoing trauma services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

**Related Category 3 Outcome Measure(s):**

OD-10 Quality of Life/Functional Status  
IT-10.2 Activities of Daily Living  

**Reasons/rationale for selecting the outcome measure:**  
Trauma impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

**Relationship to other Projects:**

Provision of Trauma Informed Care services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 133340307.2.2 Psychiatric Consultation, and 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services.) by providing specialized services addressing trauma experienced by individuals that if not addressed in the community may result in needing inpatient psychiatric services. Addressing trauma symptoms in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing trauma symptoms in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

**Relationship to Other Performing Providers’ Projects in the RHP:**

Hill Country MHDD Centers is the local mental health authority that provides services within the
following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on 200 consumers over the life of the project.
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td>Metric 1 P-2.1: Project plans based on evidence/experience and which address the project goals</td>
<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care)</td>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
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<td>Baseline: No intervention has been designed</td>
<td>Baseline/Goal: Baseline - 0 individuals beginning services; Goal 40 individuals beginning services during DY3</td>
<td>Baseline: No evidence of improvement initiatives</td>
<td>Baseline: DY4 improvement initiatives</td>
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<td>Goal: Submission of project plan</td>
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Related Category 3 Outcome Measure(s): 133340307.3.6 3.IT-10.2 Activities of Daily Living
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## Identifying Project and Provider Information:

| Title: | 2.18.1 Design, implement, and evaluate whole health peer support for individuals with mental health and/or substance use disorders: Whole Health Peer Support |
| Unique RHP ID#: | 133340307.2.5 – PASS 2 |
| Provider Name: | Hill Country Community MHMR Center (dba Hill Country MHDD Centers) |
| TPI: | 133340307 |

## Project Summary:

**Provider Description:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.

**Intervention(s):** This project will implement Whole Health Peer Support services within the 11 counties served by Hill Country in RHP6 in order to meet the overall health needs of individuals who have behavioral health issues. The project will identify and train behavioral health peers on whole health risk assessments and working with peers to address overall health issues in order to treat symptoms prior to the need for utilization of emergency departments or inpatient hospitalization.

**Need for the project:** Individuals with severe and persistent mental illness die 25 years earlier than the general population. Identifying and addressing overall health symptoms, such as hypertension, diabetes, obesity, tobacco use and physical inactivity, of individuals with severe and persistent mental illness helps address this issue while reducing emergency department utilization and potentially preventable admissions to hospitals.

**Target population:** The target population is individuals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties who have severe and persistent mental illness and other health risk factors. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.

**Category 1 or 2 expected patient benefits:** The project aims to establish Whole Health Peer Support within the 11 counties served by Hill Country in RHP6. Whole Health Peer Support will provide whole health risk assessments to individuals with severe and persistent mental illness in an effort to identify physical health issues early and begin treatment to avoid emergency department utilization and potentially preventable hospital admissions. The project seeks to provide services to a minimum of 250 individuals from the 11 counties served by Hill Country in RHP6 by the end of DY5 (25 in DY3; 100 in DY4 and 125 in DY5).

**Category 3 outcomes:** IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Whole Health Peer Support showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency...
Project Description:

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. By expanding peer services as an integral portion of the seven mental health clinics operated by Hill Country MHDD Centers and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments.

Hill Country’s is planning to utilize consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide behavioral health services. Through Via Hope, a state wide organization established under the State’s Mental Health Transformation grant, consumers are being trained to serve as whole health peer support specialists. Upon completion of training, peers are working with consumers to set achievable goals to prevent chronic diseases such as diabetes or to address when they exist. While Hill Country has begun the process of incorporating peer support services, there have been challenges with maintaining peer support specialists and fully incorporating peer services throughout the treatment process. The advancement to Whole Health Peer Support is needed along with increased emphasis on peer services in order to help individuals advance in their recovery.

In implementing this project, Hill Country will continue to train and educate clinicians on the importance of peer services, recruit and train peer specialists in the provision of Whole Health Peer Support, and utilize peer services to identify health risks and provide appropriate education and referrals regarding the health risks identified. Peer services will be tracked in Hill Country’s information technology system (Anasazi) by location and consumer in order to monitor services delivered and outcomes of the services. In addition, Hill Country will conduct consumer satisfaction surveys for individuals receiving peer support services.

Challenges:
The challenges Hill Country has faced in establishing a robust peer support program have been in relation to retaining individuals in the positions for extended periods of time. Hill Country plans to address this challenge by shifting the focus of peer support to a whole health model that becomes more fully integrated into the regular practice of the mental health clinics. In addition, Hill Country intends to increase the percentage of full time equivalent for peer support specialists in order to increase retention.

Goals:
By the end of five years, Hill Country’s goal is to have peer support specialists at each mental health clinic with a minimum full time equivalency of 7.0 and to have 20% of the consumers who participate in whole health peer support experiencing improvement in standardized health measures. Currently, Hill Country has 1.80 full time equivalency for peer support services within RHP6.
Relationship to the Regional Goals:
The goal of this project is to use Whole Health Peer Support to provide guidance and support for the consumer’s journey of recovery based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way. In addition, the establishment of the Whole Health Peer Support will help achieve the regional goal to improve the health care infrastructure to better serve the Medicaid and uninsured residents of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde, and Val Verde counties.

Starting Point/Baseline:
Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery. Currently, Hill Country MHDD Centers currently has ten peer specialists with only four having certification through the state training program. The seven mental health clinics operated by Hill Country within RHP6 currently have 1.80 full-time equivalency for provision of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the mental health clinics operated by Hill Country MHDD Centers within RHP6 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers.

Rationale:
Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. By expanding peer services as an integral portion of the seven mental health clinics operated by Hill Country MHDD Centers within RHP6 and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments. Through this project Hill Country will acquire and maintain Whole Health Peer Support Specialists equivalent to a minimum of 7.0 full time equivalency throughout the seven mental health clinics operated by Hill Country within RHP6.

Project Components:
Through the Whole Health Peer Support, Hill Country MHDD Centers proposes to meet all required project components.

A) **Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.** Hill Country MHDD Centers is currently participating in the Person Centered Recovery Initiative through Via Hope. The initiative is designed to promote mental health system transformation by 1) helping organizations develop culture and practices that support and expect recovery, and 2) promoting
consumer voice in the transformation process and the future, transformed mental health system. On October 24th, 2012, the clinical leadership of Hill Country completed a one day training on integrating peer support and incorporating the patient in developing and implementing their treatment plan.

B) **Conduct readiness assessments of organization that will integrate peer specialists into their network.** Hill Country will review readiness at the Llano Mental Health Clinic within RHP8 and address any potential barriers to full integration of Whole Health Peer Support.

C) **Identify peer specialists interested in this type of work.** Hill Country will recruit peer specialists who have interest, first and foremost, in helping others on their journey of recovery and who also wish to receive training in providing whole health peer services and are interested in employment with Hill Country MHDD to provide whole health peer services.

D) **Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity).** Hill Country MHDD Centers will make arrangements for interested peer specialists to attend Whole Health Peer Support trainings and certifications available through the state of Texas Via Hope program. If training space becomes restrictive, Hill Country will find or develop similar training to bring peer specialists on board until such time as the certification training is available.

E) **Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.** Hill Country MHDD Centers will have trained peer specialists utilize the health risk assessment tool to determine potential or current health risks, will track the completion of health risk assessments in the information technology system, and will address potential health risks with the patient.

F) **Identify patients with serious mental illness who have health risk factors that can be modified.** Patients identified through the health risk assessment tool will receive education and information regarding potential health risks and, if appropriate, referred to primary care and preventive resources.

G) **Implement whole health peer support.** Hill Country will track the occurrence of health risk assessments by location and patient in order to determine the project is fully implemented.

H) **Connect patient to primary care and preventive services.** If risk factors or medical conditions are identified that require more than basic education, individuals will be referred to the appropriate primary care and preventive services.

I) **Track patient outcomes Review the intervention(s) impact on participants and identify “lessons learned,” opportunities to scale all or part of the interventions(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.** Hill Country will utilize the Daily Living Activities assessment to determine progression of individuals receiving Whole Health Peer Support services. In addition, Hill Country will do follow up surveys with individuals who receive Whole Health Peer Support services to determine satisfaction with services and to help ensure stabilization of symptoms.
Unique community need identification number the project addresses:
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery. The seven mental health clinics operated by Hill country within RHP6 currently have 1.80 full-time equivalency of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through these mental health clinics within RHP6 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:
Whole Health Peer Support services impact an individual’s mental and physical health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living (DLA-20) will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses. THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

Relationship to other Projects:
Provision of Whole Health Peer Support services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 1333340307.2.2 Psychiatric Consultation, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.2.4 Trauma Informed Care, 133340307.2.6
Veteran Mental Health Services, and 133340307.2.7 Mental Health Courts) by providing specialized services addressing crisis episodes and aimed at averting reoccurrence of crisis episodes experienced by an individual that if not addressed in the community may result in needing inpatient psychiatric services. Addressing the crisis episode in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

**Relationship to Other Performing Providers’ Projects in the RHP:**

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program’s value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133340307.3.7</th>
<th>3.IT-10.2</th>
<th>Activities of Daily Living</th>
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<tbody>
<tr>
<td><strong>Year 1</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
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<tr>
<td>P-3: Identify and train peer specialists to conduct whole health classes</td>
<td>Metric 1 P-3.1: Number of peers trained in whole health planning</td>
<td>Goal: 4 peers trained in whole health planning during DY2</td>
<td>Data Source: Training records</td>
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<td><strong>Milestone 2</strong></td>
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<tr>
<td>P-6: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors</td>
<td>Metric 1 P-6.2: Number and quality of person centered wellness plans</td>
<td>Goal: Person centered wellness plans have been developed with 25 individuals</td>
<td>Data Source: Training records</td>
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<td><strong>Milestone 3</strong></td>
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<tr>
<td>P-4: Evaluate and continuously improve peer support services</td>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement</td>
<td>Data Source: Hill Country MHDD records</td>
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<tr>
<td>Milestone 3 Estimated Incentive Payment: $156,940.50</td>
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<td>[I-X]: Number of individuals beginning service during demonstration year</td>
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<tr>
<td><strong>Milestone 5</strong></td>
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<tr>
<td>P-4: Evaluate and continuously improve interventions</td>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement</td>
<td>Data Source: Hill Country MHDD records</td>
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<tr>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
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<tr>
<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Whole Health Peer Support)</td>
<td>Baseline/Goal: Baseline - 25 individuals beginning service in DY3; Goal – 100 additional individuals beginning services during DY4 (for an estimated cumulative total of 125);</td>
<td>Data Source: Hill Country MHDD records/EHR</td>
<td>Milestone 4 Estimated Incentive Payment: $156,940.50</td>
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<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Whole Health Peer Support)</td>
<td>Baseline/Goal: Baseline - 25 individuals beginning service in DY3; Goal – 125 additional individuals beginning services during DY5 (for an estimated cumulative total of 250);</td>
<td>Data Source: Hill Country MHDD records/EHR</td>
<td>Milestone 6 Estimated Incentive Payment: $164,428.50</td>
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| Year 2 Estimated Milestone Bundle Amount: $283,215 | Year 3 Estimated Milestone Bundle Amount: $304,236 | Year 4 Estimated Milestone Bundle Amount: $313,881 | Year 5 Estimated Milestone Bundle Amount: $328,857 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,230,189**
### Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 2.13.1</th>
<th>Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Veteran Mental Health Services</th>
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<tr>
<td>Unique RHP ID#:</td>
<td>133340307.2.6 – PASS 2</td>
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<tr>
<td>Provider Name:</td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI:</td>
<td>133340307</td>
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</table>

### Project Summary:

**Provider Description:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.

**Intervention(s):** This project will implement Veteran Mental Health Services within the 11 counties served by Hill Country in RHP6 in order to meet the overall health needs of veterans dealing with behavioral health issues. The project will expand peer support services in an effort to identify veterans and their family members who need comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration and provide the community based wrap around behavioral health services for these veterans in order to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.

**Need for the project:** Hill Country’s service area within RHP6 has a veteran population of 37,809 and veterans seeking behavioral health services currently have to travel over 300 miles and take a full day off of work to receive behavioral health services. Based on an average family size for the 11 counties served of 2.87, the veterans and their families are a total target population base for the project of 27,448. In addition, a recent study of death certificates in Texas revealed that the percentage of deaths by suicide for Texas veterans was nearly double the same rate for civilians.

**Target population:** The target population is veterans and their family members within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties who have behavioral health issues. The target population consists of the 27,448 veterans and their families, including reservists who only receive Veteran Administration benefits for 180 days after federal deployment. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.

- **Category 1 or 2 expected patient benefits:** The project aims to establish Veteran Mental Health Services within the 11 counties served by Hill Country in RHP6. Veteran Mental Health Services will provide wraparound behavioral health services to veterans and/or their family members within their local communities. The project seeks to provide services to a minimum of 180 veterans from the 11 counties served by Hill Country in RHP6 by the end of...
DY5. The cumulative anticipated number of veterans or their family members served by demonstration year is as follows: DY3 40; DY4 100; DY5 180. The anticipated number of individuals served is shown as an unduplicated number since services will carry over between demonstration years.

**Category 3 outcomes:** IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Veteran Mental Health Services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

**Project Description:**

As the mental health authority for our service area, Hill Country is well aware of the challenges for Veteran’s requiring mental health services. Currently Veteran’s within the eleven counties served by Hill Country within RHP6, including over 543 Reserve Component Service members deployed to OEF/OIF, must travel to San Antonio to receive mental health services. For a majority of these veterans, this involves over 300 miles of travel and a full day off of work for a one hour appointment. Just this year, the Veteran’s Administration contracted with Hill Country to offer Telemedicine services at the Del Rio Mental Health Clinic in order to help reduce this additional strain on the Veteran’s in the far western portion of our service area.

According to 2012 population estimates from the Texas Department of State Health Services Population Data System for Texas Population Estimates Program and statistics from the Veteran’s Administration 9/30/08 Projection of Veteran’s by 110th Congressional District, Vet Pop 2012, the eleven counties served by Hill Country within RHP6 have a total population of 401,123 with a Veteran population of 37,809, or 9.4% of the total population.

According to a study completed by the Austin American Statesman on October 1, 2012, the percentage of deaths of Texas Veterans caused by suicide from 2003 through 2011 was 21.5% compared to 12.4% for the overall Texas population. Of Texas Veterans with a primary diagnosis of post-traumatic stress disorder who died during this period, 80% died of overdose, suicide or a single-vehicle crash. During discussions Hill Country held with County Veteran Service Officers within the region, it was noted that there is a need for Mental Health services for Veterans due to the transportation and time commitment needed to access Veteran Administration services as well as the reluctance of veterans to acknowledge a potential mental health issue with the Veterans Administration.

Hill Country currently has two Veteran Peer Coordinators who recruit volunteer Veterans to provide peer support services throughout Hill Country’s 19 county, 22,000 square mile service area. Through this project, Hill Country would acquire additional Veteran Peer Coordinators who can actively work to recruit and train veteran peer support providers in a concentrated area. The Veteran Coordinators acquired through this project will create liaisons within the counties, seek out veterans and establish drop-in centers, recruit volunteers, connect veterans with other community resources, create jail outreach and jail diversion for veterans involved with the criminal justice system, coordinate medical and behavioral health referrals as appropriate and serve as a liaison with the local National Guard and Reserve units. This project will also include
provision of comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration for both Veterans and their families in Blanco and Llano counties, including reservists who only receive Veteran Administration benefits for a few months after active deployment. Wrap around services will be delivered by clinicians who have been trained in cultural competency for the military environment. Wraparound services provided through this project in the local community will complement the Psychiatrist and Counselor services provided by the Veteran Administration at the VA clinics. During the last 6 months, the Veteran Peer Support services have referred 60 individuals for mental health treatment.

Hill Country MHDD Centers will expand Veteran Peer and Mental Health services throughout the eleven county area served by Hill Country in RHP6. In establishing the project, Hill Country will review literature and experiences regarding Veteran Peer and Mental Health services to establish appropriate training for staff on the most effective interventions for veteran services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for veteran peer and community based wrap around behavioral health services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact the various stressors have on the individuals daily lives will be completed when a Veteran is referred for mental health services and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on Veteran Peer and Mental Health services delivered within the program as well as by location within the program.

Challenges:
The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

Goals:
The goal of this project is to expand Veteran Peer and Mental Health services throughout the eleven counties served by Hill Country in RHP6 in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

Relationship to the Regional Goals:
The goal of this project is to establish Veteran Peer and Mental Health services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way.
Starting Point/Baseline:

Hill Country MHDD Centers currently has one two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinators to serve two to three counties each of the eleven counties served by Hill Country in RHP6 in order to recruit and train veteran peer service providers and provide identified mental health services as needed. The DLA20 assessment will be performed on each individual referred from veteran peer services to veteran mental health services as their baseline and the percentage of individuals who have improved DAL20 scores on a subsequent assessment after treatment will be utilized to show improvement.

Rationale:

Hill Country will identify and train Veteran Peer Coordinators in the provision of veteran peer support services including identifying and seeking out veterans needing services, recruit veteran peer support providers, creating drop-in centers for veterans, identify and connecting with current resources, and incorporating jail diversion as appropriate for veterans in touch with the criminal justice system.

Project Components:

Through the Veteran Mental Health services project, Hill Country MHDD Centers proposes to meet all required project components:

A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on veterans with mental health issues and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.

B) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving veteran mental health issues in order to provide targeted training for staff.

C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment(DLA-20).

D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult*
Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of Veterans referred for Veteran Mental Health services. In addition, Hill Country will do follow up surveys with individuals who receive Veteran Peer Services to determine satisfaction with services and to help ensure stabilization of symptoms.

Unique community need identification number the project addresses:
CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country MHDD Centers currently has one two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinators to serve the eleven counties served by Hill Country within RHP6 in order to recruit and train veteran peer service providers and provide identified mental health services as needed.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:
Behavioral health issues impact veterans mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

### Relationship to other Projects:

Provision of Veteran Mental Health services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 133340307.2.2 Psychiatric Consultation, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.2.4 Trauma Informed Care, 133340307.2.5 Whole Health Peer Support and 133340307.2.7 Mental Health Courts) by providing specialized services addressing crisis episodes and aimed at averting reoccurrence of crisis episodes experienced by an individual that if not addressed in the community may result in needing inpatient psychiatric services. Addressing the crisis episode in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

### Relationship to Other Performing Providers’ Projects in the RHP:

Hill Country MHD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

### Plan for Learning Collaborative:

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

### Project Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on 90 consumers over the life of the project.
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<th>133340307.2.6_PASS 2</th>
<th>2.13.1</th>
<th>2.13.1 A-E</th>
<th>2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Veteran Mental Health Services</th>
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<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
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<td>Related Category 3 Outcome Measure(s):</td>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<td><strong>Milestone 1</strong>&lt;br&gt;P-2: Design community-based specialized intervention for target population (Veteran Mental Health)&lt;br&gt;Metric 1 P-2.1:&lt;br&gt;Baseline: No intervention has been designed&lt;br&gt;Goal: Submission of project plan&lt;br&gt;Data Source: Project documentation&lt;br&gt;Milestone 1 Estimated Incentive Payment: $426,456</td>
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<td><strong>Milestone 3</strong>&lt;br&gt;P-4: Evaluate and continuously improve interventions&lt;br&gt;Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles&lt;br&gt;Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement&lt;br&gt;Data Source: Hill Country MHDD records&lt;br&gt;Milestone 3 Estimated Incentive Payment: $236,317.50</td>
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<td><strong>Milestone 5</strong>&lt;br&gt;P-4: Evaluate and continuously improve interventions&lt;br&gt;Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles&lt;br&gt;Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement&lt;br&gt;Data Source: Hill Country MHDD records&lt;br&gt;Milestone 5 Estimated Incentive Payment: $247,593</td>
<td><strong>Milestone 6</strong>&lt;br&gt;[I-X]: Number of targeted individuals beginning service during demonstration year&lt;br&gt;</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,852,389**
Identifying Project and Provider Information:
Title: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Mental Health Courts
Unique RHP ID#: 133340307.2.7 – PASS 2
Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
TPI: 133340307

Project Summary:
Provider Description: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP6 (Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde). Hill Country serves a 14,390 square mile area of RHP6 with a population of approximately 401,123 in 2012.

Intervention(s): This project will implement Mental Health Courts within the Comal, Medina, and Uvalde counties served by Hill Country in RHP6 in order to meet the overall health needs of individuals dealing with behavioral health issues who frequently utilize the emergency departments or criminal justice system. The project will have dedicated case workers to provide wraparound services for the identified individuals and will have dedicated courts to monitor the patient’s treatment compliance.

Need for the project: Comal, Medina, and Uvalde counties have approached Hill Country regarding establishing Mental Health Courts in order to increase treatment compliance of individuals with mental illness identified as having frequent utilization of emergency departments, the criminal justice system, and/or psychiatric inpatient services in an effort to deter inappropriate utilization of these services.

Target population: The target population is individuals with mental illness from within Comal, Medina, and Uvalde counties who are frequently utilize the emergency departments, criminal justice system, and/or psychiatric inpatient services. Based on the population served in Hill Country’s behavioral health program in RHP6, approximately 32% of our behavioral health patients within RHP6 have Medicaid and approximately 82% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project aims to establish Mental Health Courts to serve Comal, Medina, and Uvalde counties within the RHP6. Mental Health Courts will monitor patient compliance with treatment protocol and provide wraparound behavioral health services to individuals in the program. The project seeks to provide services to a minimum of 120 individuals in RHP6 by the end of DY5 (number beginning service by DY: 20 in DY3; 40 in DY4; and 60 in DY5).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Mental Health Courts showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.
### Project Description:

Comal, Medina and Uvalde counties have approached Hill Country MHDD Centers regarding establishing Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. Hill Country MHDD Centers would hire Community Health Workers to serve as Case Managers to deliver necessary community-based interventions according to the individuals need. Community-based interventions may include psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services in accordance with the individuals needs. The identified consumers served through this project would appear regularly before the Mental Health court to increase the accountability of the individual to the necessary treatment in order to reduce utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings.

The mental health court in Pittsburgh, which has been operating since 2001, determined that only 10% of individuals who completed the court were rearrested compared to a 68% national average for all defendants. According to the Bureau of Justice Assistance, *when it comes to mentally ill offenders, mental health courts have shown positive outcomes related to treatment and satisfaction with the process. A common perception is that the informality and decreased adversarial nature of the mental health court, when compared to traditional courts, decreases the barriers mentally ill offenders often face in receiving treatment through traditional courts. Mental health courts have been shown to provide more treatment, better treatment and faster linkages to appropriate treatment.*

In other studies, a 2003 study of the Broward County (Fla.) mental health court determined that the program increased defendants’ access to treatment services and that mental health court participants were more likely that non-participants to continue treatment after the program concluded. Another 2003 study of the Clark County (Wash.) mental health court, concluded participants had significantly more case management, outpatient service days, and medication monitoring after enrollment than before enrollment. Additionally, participants had fewer crisis intervention and inpatient treatment days post-enrollment.

In designing the Mental Health Courts, Hill Country will work with the courts to review other successful mental health courts, identify the target population to be served, have dedicated case managers for the courts, develop necessary legal agreements for court participation, create linkages for services beyond mental health services, and work with the courts in establishing ongoing procedures.

### Challenges:

The primary challenge for implementation of the project is recruiting qualified staff dedicated to working with the target population. Hill Country will address the challenge by offering incentives as necessary.

### Goals:

The goal of this project is to develop Mental Health Courts in Comal, Medina and Uvalde counties in order to reduce emergency department utilization, inpatient utilization, and
incarceration by developing wrap around services within the community for the targeted population.

Relationship to the Regional Goals:
The goal of this project is to establish Mental Health Courts within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way.

Starting Point/Baseline:
Hill Country MHDD Centers does not currently have a mental health court within its service area. This will be a new program for the area.

Rationale:
Comal, Medina and Uvalde counties have approached Hill Country MHDD Centers regarding establishing Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. Hill Country MHDD Centers would hire Community Health Workers to serve as Case Managers to deliver necessary community-based interventions according to the individuals need. Community-based interventions may include psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services in accordance with the individuals needs. The identified consumers served through this project would appear regularly before the Mental Health court to increase the accountability of the individual to the necessary treatment in order to reduce utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings.

In designing a program to address the needs of individuals with mental illness identified with frequent utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings, Hill Country MHDD Centers will:

A) Assess size, characteristics and needs of individuals with mental illness identified with frequent utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings, Hill Country will work with the local court systems to identify a target population that would gain the greatest benefit from participating in a mental health court to determine the size and characteristics of the population to be served. Hill Country will also review with the court the Sequential Intercept Model to determine the most appropriate level of entry for participants.

B) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. Hill Country will visit successful mental health courts and review literature on lessons learned from other mental health courts in order to develop targeted services, forms and procedures in establishing the mental health courts and associated services.
C) **Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.** Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment (DLA-20).

D) **Design models which include an appropriate range of community-based services and residential supports.** Based on the size, characteristics and needs for the target population, Hill Country will train staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) **Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the ANSA and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.** Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of Mental Health Court participants. In addition, Hill Country will do follow up surveys with individuals who receive Mental Health Court services to determine satisfaction with services and to help ensure stabilization of symptoms.

Unique community need identification number the project addresses:
- CN.4 There is a shortage of high quality mental and behavioral health services that are integrated with physical

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
There are currently no mental health courts within Hill Country’s service area.

**Related Category 3 Outcome Measure(s):**

OD-10 Quality of Life/Functional Status  
IT-10.2 Activities of Daily Living  

Reasons/rationale for selecting the outcome measure:
Criminal justice involvement and recurrence of emergency department utilization impact an individuals mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional
deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.


**Relationship to other Projects:**

Provision of Mental Health Court services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 6 (133340307.2.1 Mobile Crisis Outreach Teams, 133340307.2.2 Psychiatric Consultation, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.2.4 Trauma Informed Care, 133340307.2.5 Whole Health Peer Support and 133340307.2.6 Veteran Mental Health Services) by providing specialized services addressing crisis episodes and aimed at averting reoccurrence of crisis episodes experienced by an individual that if not addressed in the community may result in needing inpatient psychiatric services. Addressing the crisis episode in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

**Relationship to Other Performing Providers’ Projects in the RHP:**

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 6: Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde. The other three local mental health authorities (Bluebonnet Trails, Camino Real, and Center for Healthcare Services) provides mental health services to the remaining counties within Regional Healthcare Partnership 6 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is
based on 120 consumers over the life of the project.
<table>
<thead>
<tr>
<th>133340307.2.7</th>
<th>2.13.1</th>
<th>2.13.1 A-E</th>
<th>2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Mental Health Courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS 2</td>
<td></td>
<td></td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers) TPI - 133340307</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>133340307.3.9</td>
<td>3.IT-10.2</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>P-2: Design community-based specialized intervention for target population (Mental Health Courts)</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
<td>P-4: Evaluate and continuously improve interventions</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
</tr>
<tr>
<td>Metric 1 P-2.1:</td>
<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court)</td>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
</tr>
<tr>
<td>Baseline: No intervention has been designed</td>
<td>Baseline - 0 individuals served; Goal - 20 individuals beginning service during DY3</td>
<td>Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
</tr>
<tr>
<td>Goal: Submission of project plan</td>
<td>Data Source: Hill Country MHDD records/EHR</td>
<td>Data Source: Hill Country MHDD records</td>
<td>Data Source: Hill Country MHDD records</td>
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<tr>
<td>Data Source: Project documentation</td>
<td></td>
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<tr>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 6</strong></td>
<td></td>
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<tr>
<td>P-4: Evaluate and continuously improve interventions</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>[I-X]: Number of individuals beginning service during demonstration year</td>
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</tr>
<tr>
<td>Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement</td>
<td>Data Source: Hill Country MHDD records</td>
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<tr>
<td>Data Source: Hill Country MHDD records</td>
<td></td>
<td>Milestone 5 Estimated Incentive Payment: $138,448.50</td>
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<tr>
<td>Milestone 6 Estimated Incentive Payment: $138,448.50</td>
<td><strong>Milestone 6</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $307,433</td>
<td>Year 3 Estimated Milestone Bundle Amount: $300,336</td>
<td>Year 4 Estimated Milestone Bundle Amount: $290,960</td>
<td>Year 5 Estimated Milestone Bundle Amount: $276,897</td>
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<td>-------------------------------------------------</td>
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<tr>
<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court) Baseline/Goal: Baseline - 0 individuals served; Goal – 40 individuals beginning service during DY4 (for an estimated cumulative total of 60) Data Source: Hill Country MHDD records/EHR Milestone 4 Estimated Incentive Payment: $145,480</td>
<td>Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court) Baseline/Goal: Baseline - 0 individuals served; Goal - 60 individuals beginning service during DY5 (for an estimated cumulative total of 120) Data Source: Hill Country MHDD records/EHR Milestone 6 Estimated Incentive Payment: $138,448.50</td>
<td>demonstration year</td>
<td>demonstration year</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,175,626**
Identifying Project and Provider Information:

<table>
<thead>
<tr>
<th>Title: 2.6.4 Implement other evidence-based health promotion program in an innovative manner: Comprehensive Teen Pregnancy Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 091308902.2.1 - PASS 1</td>
</tr>
<tr>
<td>Performing Provider: San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>Performing Provider TPI: 082426001</td>
</tr>
</tbody>
</table>

Project Summary:

Provider Description: The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals.

Intervention(s): The Metro Health teen pregnancy prevention project will include the following four components. 1) Educate adolescents in Bexar County zip codes that have high teen birth and STD rates using evidence-based teen pregnancy, STD & HIV prevention programs. 2). Expand access to affordable reproductive healthcare services for adolescents that may not be reached through existing provider practices and focusing on segments of the population with high teen birth and STD rates. 3). Conduct training to providers on the Adolescent Medical Home (AMH) model encouraging a team-based care approach to preventive adolescent health services. 4). Provide case management services to teen mothers through the evidence-based Healthy Outcomes through Perinatal Education and Support (HOPES) project to reduce repeat teen pregnancies. The project provides a diverse intervention spectrum ranging from intensive short term services to long-term follow-up over an extended period of time to best meet the needs of the target population. Milestones 4, 8, 12 and 16 for DY2-DY5 include CQI activities as a part of the RHP 6 learning collaborative.

Need for the project: San Antonio has a critical need for effective teen pregnancy prevention strategies in order to stimulate and sustain long-term changes in adolescent behavior and healthcare. The 2010 San Antonio’s Bexar County birth rate for females ages 10-14 was 0.7/1,000 and was 75% higher than the national rate 0.4/1,000. In 2010, the Bexar County teen childbearing cost was $69.9 million dollars in health care, child welfare, incarceration, and lost revenue.

Target population: The target population will be adolescents 13 to 19 years of age who reside in zip codes where teen births rates are over twice the national birth rate. The project intends to reach over 1,550 adolescents for each year (DY3 thru DY5) for a total of 4,650 adolescents reached. Approximately 80% of the target population are eligible for Medicaid and would benefit from preventive education and health services proven to change adolescent sexual behavior.

Category 1 or 2 expected patient benefits: For each year (DY3 thru DY5), the project seeks to reach 1,200 adolescents with evidence-based teen pregnancy, STD & HIV prevention education,
100 teen mothers with case management services, 250 adolescents with reproductive healthcare services, and 20 medical providers with education encouraging a team based care approach using an adolescent medical home model. The number of adolescents reached for each year (DY3 thru DY5) will be 1,550 for a total number of 4,650 adolescents reached.

**Category 3 outcomes:**

**OD-2 Potentially Preventable Admissions**

**IT-2.13 Other Admission Rate – Admissions for infant delivery among health education participants**

- A reduction in the proportion of adolescents reporting a teen pregnancy among those participating in the evidence-based teen pregnancy, STD, and HIV prevention education component compared to baseline.

**IT-2.13 Other Admission Rate – Admission for infant delivery among case management participants**

- A reduction in the proportion of repeat teen pregnancies among teen mothers participating in the HOPES case management component.

**Project Description:**

**Project Overview**

San Antonio Metropolitan Health District (Metro Health) submits this proposal with the overall goal to reduce the burden of adolescent pregnancy and improve the health status of adolescents in San Antonio, TX.

San Antonio has several challenges and has a critical need for effective teen pregnancy prevention strategies in order to stimulate and sustain long-term changes in adolescent behavior and healthcare. The 2010 San Antonio’s Bexar County birth rate for females ages 10-14 was 0.7/1,000 and was 75% higher than the national rate 0.4/1,000. According to the latest comparable data, Bexar County’s 2008 pregnancy rate for females ages 10-14 was 1.9/1,000 and was 36% higher than the national pregnancy rate of 1.4/1,000. The number of Syphilis and HIV cases among youth ages 13-19 increased by 77% in Bexar County from 2006 to 2010. During the same period, reported cases of Chlamydia and Gonorrhea increased to 31% and 29% respectively for the same age group. In 2010, seven zip codes had teen birth rates for females ages 15-19, 3 to 4 times the national teen birth rate of 76.9/1,000 females age 15–19.

In addition, funding for family planning and reproductive health services have been cut by two thirds in Texas, reducing access to services for adults and adolescents. One local health care provider has reported that state funding cuts have reduced preventive care and family planning services from more than 10,000 patients per year to approximately 2,300 today. Nearly 57% of Texas deliveries are paid for by Medicaid, and 47% of Texas births are the result of unplanned pregnancies.

This project will address the challenges with four components that will work in conjunction to support the project goal;

1. Educate adolescents in Bexar County zip codes that have high teen birth and STD rates using evidence-based teen pregnancy, STD & HIV prevention programs. The project will work with school districts and charter schools within Bexar County to implement district-wide, age and culturally appropriate evidence-based teen pregnancy, STD & HIV prevention education. Part of the prevention education will include information on where
adolescents can go for healthcare services.

2. Expand access to affordable reproductive healthcare services for adolescents that may not be reached through existing provider practices and focusing on segments of the population with high teen birth and STD rates. The project will work with local providers to increase the number of adolescents receiving reproductive healthcare services.

3. Conduct training to providers on the Adolescent Medical Home (AMH) model. The AMH model encourages a team-based care approach to preventive adolescent health services and making efforts to link payment to performance. The project will work with educating area providers on how to establish an AMH model in their practices to provide comprehensive healthcare services to new and existing adolescent patients.

4. Provide case management services to teen mothers through the evidence-based Healthy Outcomes through Perinatal Education and Support (HOPES) project to reduce repeat teen pregnancies. The HOPES Project is a client-centered, solution-focused, home visitation model implemented by a complement of Nurse and Social Worker staffing and based on the Inter-conception Health Promotion Initiative in Denver, CO. Health promotion is accomplished through identification of strengths on which to build, education, patient navigation, modeling, counseling, advocacy and motivational interviewing. The project will work with providers to identify and recruit teen mothers for the HOPES project.

**Goals and Relationship to Regional Goals**

**Project Goals:**
- 1. Reduce teen pregnancies among higher risk target populations
- 2. Reduce repeat teen pregnancies among teens in case management services

This project meets the following regional goals:

This project directly addresses the RHP 6 need to provide improved maternal and child health services within the region (CN.5).

**Challenges:**

San Antonio has several challenges and has a critical need for effective teen pregnancy prevention strategies in order to stimulate and sustain long-term changes in adolescent behavior and healthcare. The 2010 San Antonio’s Bexar County birth rate for females ages 10-14 was 0.7/1,000 and was 75% higher than the national rate 0.4/1,000.

These challenges will be addressed through a multipronged strategy to reduce teen pregnancy through evidence-based education, case management, clinical services and provider outreach and education.

**5-Year Expected Outcome for Provider and Patients:**
The five year expected outcome will be to reduce the Bexar County teen birth rate for females ages 15-19 by 15%.

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### Starting Point/Baseline:

Currently teen pregnancy prevention services are provided by Metro Health and project partners as follows:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teen Pregnancy Prevention Education Services</strong></td>
<td>500 teens currently served, 2 of providers trained in project, 42 educational encounters, (Oct 2011 - June 2012)</td>
</tr>
<tr>
<td><strong>Expansion of Adolescent Reproductive Health Care Services</strong></td>
<td>100 teens currently served, 1 provider trained in project, 150 clinical encounters, (September 2012)</td>
</tr>
<tr>
<td><strong>Adolescent Medical Home Services</strong></td>
<td>This program does not currently exist. Baseline of 0 for DY2</td>
</tr>
<tr>
<td><strong>Teen Case Management Services</strong></td>
<td>This program does not currently exist. Baseline of 0 for DY2</td>
</tr>
</tbody>
</table>

### Rationale:

The Centers for Disease Control and Prevention (CDC) has listed teen pregnancy as a “Winnable Battle” if communities implement evidence-based prevention programs. However, only twelve Bexar County area schools are using evidence-based teen pregnancy, STD & HIV education programs. In addition, existing community health clinics have reached their capacity for adding new adolescent patients, while medical providers have limited funding to provide more comprehensive health evaluation, prevention health screenings and referrals. The Metro Health project components and outcomes were specifically selected to address these critical challenges and will significantly expand evidence-based prevention education, adolescent reproductive health services, provider knowledge on implementing an AMH model, and intensive case management for teen mothers.

**Unique community need identification number the project addresses:**

The Metro Health project rationale includes a wide reaching strategy for adolescent prevention education and health services currently lacking in Bexar County and associated with RHP 6 community need CN.5.

According to the National Campaign to Prevent Teen and Unplanned Pregnancy, parenthood is the leading cause of school dropout among teen girls and young teen mothers are much less likely to graduate from high school than those who wait to become parents.[4] The disparities in teen pregnancy and school drop outs are more notable among Latinos. In a May 2010 publication, The National Campaign reported that more than half (54%) of Latina teen mothers do not complete high school, compared to 34% of teen mothers overall.[5] In Bexar County, Hispanic teens have historically had teen birth rates well above national averages. In 2010, Metro Health recorded a birth rate of 64.0/1,000 births to Hispanic females ages 15-19 compared to the national rate of 55.7/1000.

Teen pregnancy affects the entire community, not just young mothers. As noted above, school dropout and adolescent pregnancy is closely linked. Teen fathers are also more likely to drop out
of school, have poor involvement with their children, engage in substance abuse and illegal activity, and conceive children with multiple women.\textsuperscript{64} In a study of children of mothers aged 17 and younger, it was found that these children had lower general knowledge scores compared with children of mothers age 20-21. Children of the youngest mothers also had significantly lower test and assessment scores than children of mothers aged 22-29, suggesting that as maternal age at birth increases, so do children’s cognition and knowledge levels by the time they reach kindergarten.\textsuperscript{65} There is an obvious economic impact on the families created by teen pregnancy, but also one that is spread community-wide. In Bexar County alone, in 2010, teen childbearing cost $69.9 million dollars in health care, child welfare, incarceration, and lost revenue.

In 2012, the City of San Antonio conducted a Community Survey among San Antonio residents in all ten City Council Districts. Teen pregnancy was ranked the highest concern among fifteen community issues and respondents felt that teen pregnancy was the most important for the City to address over the next two years.\textsuperscript{66} In 2011, Metro Health initiated a strategic planning process both internally and community-wide in which teen pregnancy was identified as one of the priority issues for San Antonio. In 2009, San Antonio Mayor, Julian Castro identified teen pregnancy as one of the most important issues to address within the SA2020 visioning process and has enlisted Metro Health to take the lead on moving the vision forward.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project would more than double the number of teens served through evidence-based health education programs and adolescent reproductive health care services. Additionally the addition of outreach and education to health care providers to promote an adolescent medical home model and case management services for teen mothers are new strategies for teen pregnancy prevention proposed in this project.

**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>OD-2 Potentially Preventable Admissions</th>
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</thead>
<tbody>
<tr>
<td>IT- 2.13 Other Admission Rate – Admissions for infant delivery among health education participants</td>
</tr>
<tr>
<td>IT-2.13 Other Admission Rate – Admission for infant delivery among case management participants</td>
</tr>
</tbody>
</table>

**Reasons/rationale for selecting the outcome measures:**
The Metro Health comprehensive strategy for teen pregnancy, STD, and HIV prevention project


\textsuperscript{65} Terry-Mumen, E., Manlove, J., Moore, K. January 2005. *How Children Born to Teen Mothers Fare*.

\textsuperscript{66} 2012 City of San Antonio Community Survey Final Report. ETC Institute.
has two Category 3 Outcomes. 1) A reduction in the proportion of adolescents reporting a teen pregnancy among those participating in the evidence-based teen pregnancy, STD, and HIV prevention education component compared to baseline. 2) A reduction in the proportion of repeat teen pregnancies among teen mothers participating in the HOPES project component. These will both be reported as potentially preventable hospital admissions to deliver infants, however additional healthcare costs and negative social outcomes will be averted by reducing teen pregnancies.

These Metro Health outcomes are a priority for the RHP as supported by local birth and STD data. According to 2010 birth certificate data collected by Metro Health, the Bexar County teen birth rate for females ages 10 to 14 (0.7/1,000) was 75% higher than the national rate of 0.4/1,000. The Bexar County teen birth rate for females 15 to 19 (50.3/1000) was 47% higher than the national rate of 34.3/1000. In 2010, Bexar County recorded 735 repeat births among females ages 19 and under (22% of all teen births were repeat births). In 2010, seven zip codes had teen birth rates for females ages 15-19, 3 to 4 times the national teen birth rate of 76.9/1,000 females age 15–19. Those zip codes were concentrated in the inner-city’s Westside, Eastside and Southside (78208, 78202, 78203, 78220, 78204, 78207, and 78214). The number of Syphilis and HIV cases among youth ages 13-19 increased by 77% in Bexar County from 2006 to 2010. During the same period, reported cases of Chlamydia and Gonorrhea increased to 31% and 29% respectively for the same age group. According to the latest comparable data.

The CDC is recommending that communities implement evidence-based strategies to prevent teen pregnancy. Metro Health is using the CDC and the locally produced Community Health Improvement Plan (CHIP) recommendations to implement proven prevention programs to decrease local teen birth rates. Strategies that include evidence-based prevention education, adolescent health services and case management, along with provider education and input are essential components of an effective strategy to combat teen pregnancy, STD/HIV transmission, and sustain long-term community change.

Compared to California, a state with similar demographics to Texas, the affect of different approaches to teen pregnancy prevention are clear. Beginning in 1990, California began implementing evidence based prevention programs, expanding teens’ access to healthcare services, and promoting media campaign messages. California teen birth rates dropped from 71/1,000 for females ages 15-19 in 1990 to 38/1,000 in 2008. Unfortunately, Texas did not follow the same strategy and saw the 1990 birth rate of 75/1,000 females ages 15-19 dropped to only 63/1,000 in 2008. Evidence-based prevention programs implemented in Bexar County could result in 1,700 fewer births each year and save five million dollars in direct costs, and thirty-three million in overall costs, annually. In addition, case management intervention has been proven effective in reducing repeat births by up to 17%, utilizing the HOPES Project model.

68 Tortelero, S. 2010. Reducing Teen Pregnancy in Texas. The University of Texas Health Science Center – Houston School of Public Health.
69 LW Loomis, MW Martin - Family & Community Health, 2000 - journals.lww.com
### Relationship to other Projects:
The Metro Health comprehensive strategy for teen pregnancy, STD, and HIV prevention supports Metro Health’s pass 2 proposed project (2.7.6) to expand Syphilis and HIV prevention and screening among high risk populations. The teen pregnancy prevention education component will build knowledge and resistance skills among adolescents to prevent STD and HIV, including information on testing. The provider education component on the AMH model will encourage provider–client discussions on STD prevention and testing. The expansion of adolescent healthcare services component will strengthen provider-client discussions on disease prevention, provide condoms for sexually active youth, and STD and HIV testing and treatment. The HOPES component will also support prevention education and encourage STD and HIV screening for teen mothers and their partners. In addition, the HOPES component will support and reinforce the Metro Health pass 2 proposed project (2.7.5) for breastfeeding promotion project to increase the percent of participating mothers’ who breastfeed for six months. Teen mothers in the HOPES project will participate in the peer support groups and baby café components of the breastfeeding project.

### Relationship to Other Performing Providers’ Projects in the RHP:
This project may align to goals of University Health System’s Healthy U School Based Clinic project in expanding access to adolescent focused clinical preventive services.

### Plan for Learning Collaborative:
Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 4, 8, 12 and 16 beginning in DY2. Additionally Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.

### Project Valuation:
In 2008, Texas taxpayer costs associated with children born to teen mothers included: $221 million for public health care (Medicaid and CHIP); $111 million for child welfare; and, for children who have reached adolescence or young adulthood, $175 million for increased rates of incarceration and $378 million in lost tax revenue due to decreased earnings and spending. According to the Health and Human Services Commission, Medicaid costs average $2,500 per infant delivery and as much as $45,000 for an infant treated in the Neonatal Intensive Care Unit.

Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following:

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factors in assigning a value to this health promotion project: achievement of waiver goals, community need, project scope and the level of project investment.

- This project was ranked high on achievement of waiver goals given the strong research and high potential for reduction of healthcare costs associated with prenatal care and teen childbearing for Medicaid and other underserved populations in Bexar County. This project will expand access to health services, emphasize effective evidence-based preventive services, provide opportunities for coordinated care between public health, school, community clinics and private providers and reduce costs.

- This project was ranked high in regards to addressing a community need. Teen pregnancy prevention is consistently listed as the leading health and social need in Bexar County and has been established as one of four key priorities for Metro Health.

- This project was ranked high on project scope in that services will be broadly targeted to all local schools and healthcare providers in Bexar County serving potentially thousands of teens through a mix of population-based and individually focused health promotion services.

- This project was ranked high in regards to program investment driven by the broad scope of population-based project activities as well as the expense of intensive individual case management and/or clinical services that will be provided through this project. The project provides a diverse intervention spectrum ranging from intensive short term services to long-term follow-up over an extended period of time to best meet the needs of the target population.
<table>
<thead>
<tr>
<th>091308902.2.1 PASS 1</th>
<th>2.6.4</th>
<th>N/A</th>
<th>2.6.4 IMPLEMENT OTHER EVIDENCE-BASED HEALTH PROMOTION PROGRAMS IN AN INNOVATIVE MANNER: COMPREHENSIVE TEEN PREGNANCY PREVENTION</th>
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<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
<td>Other Admission Rate</td>
<td>Other Admission Rate</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>091308902.3.4 091308902.3.5</td>
<td>IT-2.13 IT-2.13</td>
<td>Other Admission Rate</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**
[P-X]: Establish program plan to provide evidence-based teen pregnancy and STD prevention education in school settings

**Metric 1**
[P-X-1]: Establish educational program implementation plan and schedule with schools

**Baseline/Goal**: Establish educational program implementation plan and schedule with schools to implement in academic year 2013-2014.

**Data Source**: MOUs with schools, program schedule

**Metric 2**
[P-X-2]: Establish contract(s) with trained educational program provider(s) to implement classes

**Baseline/Goal**: Establish contract with one or more trained and qualified partners to conduct classes

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**Milestone 5**
[I-X]: Increase number of adolescents receiving evidence-based programming in schools

**Metric 1** [I-6-1]: Number of teens who received evidence-based programming in schools

**Goal**: 1200 teens

**Data Source**: School documentation of number of teen participants

**Milestone 5 Estimated Incentive Payment**: $936,387.50

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**Milestone 6**
[I-X]: Increase access for adolescent clinical preventive health services

**Metric 1** [I-X-1]: Number of Teens receiving comprehensive preventive health services for

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**Milestone 9**
[I-X]: Increase number of adolescents receiving evidence-based programming in schools

**Metric 1** [I-6-1]: Number of teens who received evidence-based programming in schools

**Goal**: 1200 teens

**Data Source**: School documentation of number of teen participants

**Milestone 9 Estimated Incentive Payment**: $946,065.75

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**Milestone 10**
[I-X]: Increase access for adolescent clinical preventive health services

**Metric 1** [I-X-1]: Number of Teens receiving comprehensive preventive health services for

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**Milestone 13**
[I-X]: Increase number of adolescents receiving evidence-based programming in schools

**Metric 1** [I-6-1]: Number of teens who received evidence-based programming in schools

**Goal**: 1200 teens

**Data Source**: School documentation of number of teen participants

**Milestone 13 Estimated Incentive Payment**: $967,842.25

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**Milestone 14**
[I-X]: Increase access for adolescent clinical preventive health services

**Metric 1** [I-X-1]: Number of Teens receiving comprehensive preventive health services for
Milestone 1 Estimated Incentive Payment: $897,595.75

**Milestone 2**

[P-X]: Establish program plan to provide adolescent clinical preventive services

Metric 1 [P-X-1]: Establish contract(s) with healthcare providers to establish a teen clinic
Baseline/Goal: Establish contract and initiate teen clinic services
Data Source: Contract

Metric 2 [P-X-2]: Establish contract(s) with partner to provide outreach and educational services to medical providers to promote the adolescent medical home model
Baseline/Goal: Establish contract and initiate outreach and promotion activities
Data Source: Contract

Milestone 2 Estimated Incentive Payment: $897,595.75

**Milestone 3**

[P-X]: Establish program plan to provide case management services to teen mothers to prevent repeat teen pregnancy

Milestone 3 Estimated Incentive Payment: $936,387.50

**Milestone 4**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 1[I-6-1]: Number of teen mothers who enroll in the HOPES case management program
Baseline/Goal: 100 new enrollees
Data Source: HOPES Program Enrollment Report

Milestone 7 Estimated Incentive Payment:

**Milestone 5**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 1[I-6-1]: Number of teen mothers who enroll in the HOPES case management program
Baseline/Goal: 100 new enrollees
Data Source: HOPES Program Enrollment Report

Milestone 11 Estimated Incentive Payment:

**Milestone 6**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 2 [I-X-2]: Number of healthcare providers participating in adolescent medical home model trainings
Baseline/Goal: 20 trained providers
Data Source: Training Logs

Milestone 6 Estimated Incentive Payment: $936,387.50

**Milestone 7**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 2 [I-X-2]: Number of healthcare providers participating in adolescent medical home model trainings
Baseline/Goal: 20 trained providers
Data Source: Training Logs

Milestone 10 Estimated Incentive Payment: $946,065.75

**Milestone 8**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 2 [I-X-2]: Number of healthcare providers participating in adolescent medical home model trainings
Baseline/Goal: 20 trained providers
Data Source: Training Logs

Milestone 14 Estimated Incentive Payment: $967,842.25

**Milestone 9**

[I-X]: Provide case management services to teen mothers to prevent repeat teen pregnancy

Metric 2 [I-X-2]: Number of healthcare providers participating in adolescent medical home model trainings
Baseline/Goal: 20 trained providers
Data Source: Training Logs

Milestone 15 Estimated Incentive Payment:
<table>
<thead>
<tr>
<th>Milestone 3 Estimated Incentive Payment: $897,595.75</th>
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</table>
| **Metric 1 [P-X-1]**: Develop a recruitment plan for teen case management services  
Baseline/Goal: Establish a plan and a diverse set of partner agencies to support case management recruitment activities  
Data Source: Recruitment Plan and MOUs with referral agencies |
| **Milestone 8**  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Data Source: Recruitment Plan and MOUs with referral agencies |
| **Milestone 12**  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Data Source: Recruitment Plan and MOUs with referral agencies |
| **Milestone 16**  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Data Source: Recruitment Plan and MOUs with referral agencies |

| Milestone 4  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Data Source: Recruitment Plan and MOUs with referral agencies |
|---|
| **Metric 1 [P-6-1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-6-2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls.  
Data Source: Catalogue of challenges, solutions, tests, and progress shared by the provider |
| **Metric 1 [P-6-1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-6-2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls.  
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| **Metric 1 [P-6-1]**: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| **Metric 2 [P-6-2]**: Share challenges and solutions successfully during this bi-weekly interaction.  
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls.  
Data Source: Catalogue of challenges, solutions, tests, and progress shared by the provider |
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<tr>
<th>Phone calls, slides from webinars, and/or meeting notes</th>
<th>Metric 2 [P-6-2]: Share challenges and solutions successfully during this bi-weekly interaction.</th>
<th>Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.</th>
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<tr>
<td></td>
<td>Participating provider during each bi-weekly interaction.</td>
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<td>Milestone 4 Estimated Incentive Payment: $897,595.75</td>
<td>Milestone 12 Estimated Incentive Payment: $946,065.75</td>
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<td></td>
<td>Milestone 8 Estimated Incentive Payment: $936,387.50</td>
<td>Milestone 16 Estimated Incentive Payment: $967,842.25</td>
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<td>Year 3 Estimated Milestone Bundle Amount: $3,745,550</td>
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<td>Year 5 Estimated Milestone Bundle Amount: $3,871,369</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $14,991,565**
Identifying Project and Provider Information:
Title: 2.6.4 Implement other evidence-based health promotion program in an innovative manner:
Neighborhood Based Physical Activity and Health Promotion Project
Unique RHP ID#: 091308902.2.2 - PASS 1
Performing Provider: San Antonio Metropolitan Health District
Performing Provider TPI: 082426001

Project Summary:
Provider Description: The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals.

Intervention(s): In order to address the obesity and diabetes rates within San Antonio/Bexar County, Metro Health will implement the Neighborhood Based Physical Activity and Health Promotion Project. This project will focus on primary prevention strategies at the community level to improve the health status of residents and increase community member engagement in a neighborhood-based approach for chronic disease prevention. Metro Health will identify 10 target area neighborhoods for this initiative based on the prevalence of risk factors for chronic disease, as well as the presence of a network of community based assets that will facilitate opportunities for resident-led health improvements. Each target neighborhood will encompass an average area of 2 square miles. Based on local population density of 1332 residents per square mile we expect that approximately 26,500 residents will be reached through community based programmatic and infrastructure improvements in health disparity neighborhoods. The project staff will work directly within target neighborhoods to engage residents in the assessment, planning, implementation and evaluation of health improvement strategies at the neighborhood level in line with the CDC’s community level strategies for Obesity Prevention as well as the Institute of Medicine’s recommended strategies for obesity prevention. Specifically, these include twenty-four specific community-level strategies in the following categories:

- Promote the availability of affordable health food and beverages
- Support healthy food and beverage choices
- Encourage breastfeeding
- Encourage physical activity or limit sedentary activity among children and youth
- Create safe communities that support physical activity
- Encourage communities to organize for change

Residents will participate in planning and selection from among these evidence-based strategies.

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72 Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity I the United States. MMWR 2009; 58(No. RR-7).

73 Institute of Medicine (U.S.), Committee on Accelerating Progress in Obesity Prevention (2012). “Accelerating Progress in Obesity Prevention: Solving the weight of the nation”.

1022 ★ RHP 6 Plan ★ March 8, 2013 San Antonio Metropolitan Health District
based on the specific needs of their neighborhood through a coordinated resident-driven process utilizing the Asset Based Community Development Model\textsuperscript{74}. Through the combination of evidence-based obesity prevention strategies and a validated model for community engagement this project will incorporate two major overarching themes to support chronic disease prevention: the tangible application of policy, systems and environmental strategies, and a community-based participatory approach that leverages resident knowledge, experience and priorities to guide change through participation and empowerment.

Continuous Quality Improvement components required of this project will include project specific training and technical assistance to be provided by the Asset Based Community Development Institute as well as active participation in the RHP6 learning collaborative and internal Metro Health team to support CQI.

**Need for the project:** This project addresses the RHP 6 need to provide improved prevention of chronic diseases including diabetes within the region (CN.2). San Antonio/Bexar County experiences a high death and disease burden related to chronic illnesses, with significant health disparities in diabetes and obesity within the urban core. The *Neighborhood Based Physical Activity and Health Promotion Project* will allow Metro Health and its partners to target resources and programs within the most vulnerable communities/neighborhoods, and capitalize on resident assets and engagement to drive decision making. This approach will focus on increasing population-wide opportunities for physical activity and healthy eating within the urban core of San Antonio through a coordinated application of multiple evidence-based strategies that will be selected by allowing community members to fully engage in deciding which approaches will work best within their neighborhood.

**Target population:** Residents living within 10 defined target neighborhoods to be identified during the initial phases of the project. Community wide data indicates 15.4\% of the total population is Medicaid eligible, the percentage of Medicaid eligible residents is expected to be higher in target neighborhoods as these will be documented health disparity areas.

**Category 1 or 2 expected patient benefits:** This project will work to improve the health status of residents and increase community member engagement in a neighborhood-based approach for chronic disease prevention. The project aims to improve healthy eating practices and increase physical activity behaviors among residents in target neighborhoods in order to reduce the prevalence of obesity and ultimately obesity-related chronic diseases among adults, adolescents and children. Each target neighborhood will encompass an average area of 2 square miles. Based on local population density of 1332 residents per square mile we expect that approximately 26,500 residents will be reached through community based programmatic and infrastructure improvements in health disparity neighborhoods.

**Category 3 outcomes:**

OD – 12 Primary Care and Primary Prevention

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\textsuperscript{74} Kretzmann, JP., McKnight JL. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community’s Assets. The Asset Based Community Development Institute, Northwestern University. 1993.
The outcome measures for the *Neighborhood Based Physical Activity and Health Promotion Project* include increasing the proportion of adults who engage in regular physical activity, and increase the proportion of adults who consume the recommended amount of fruits and vegetables, and decrease the proportion of adults that are overweight or obese (BMI>25). These indicators will be measured using the Behavior Risk Factor Surveillance System (BRFSS) survey questions.

- IT – 12.6 – Other Outcome Improvement Target – increase the % of adults who consume the recommended amount of fruits and vegetables
- IT – 12.6 – Other Outcome Improvement Target – increase in % of adults who are physically active
- IT – 12.6 – Other Outcome Improvement Target – Decrease the % of adults that are overweight or obese (BMI>25)

**Project Description:**

**Project Overview**

In order to address the obesity and diabetes rates within San Antonio/Bexar County, Metro Health will implement the *Neighborhood Based Physical Activity and Health Promotion Project*. This project will work to improve the health status of residents and increase community member engagement in a neighborhood-based approach for chronic disease prevention. This project addresses the RHP 6 need to provide improved prevention of chronic diseases including diabetes within the region (CN.2).

Metro Health will identify 10 target area neighborhoods for this initiative based on the prevalence of risk factors for chronic disease, as well as the presence of a network of community based assets that will facilitate opportunities for resident-led health improvements. The project staff will work directly within target neighborhoods to engage residents in the assessment, planning, implementation and evaluation of health improvement strategies at the neighborhood level in line with the CDC’s community level strategies for Obesity Prevention\(^1\) as well as the Institute of Medicine’s recommended strategies for obesity prevention\(^2\). Specifically, these include twenty-four specific community-level strategies in the following categories:

- Promote the availability of affordable health food and beverages
- Support healthy food and beverage choices
- Encourage breastfeeding
- Encourage physical activity or limit sedentary activity among children and youth
- Create safe communities that support physical activity
- Encourage communities to organize for change

Residents will participate in planning and selection from among these evidence-based strategies based on the specific needs of their neighborhood through a coordinated resident-driven process utilizing the Asset Based Community Development Model\(^3\). Through the combination of evidence-based obesity prevention strategies and a validated model for community engagement this project will incorporate two major overarching themes to support chronic disease prevention: the tangible application of policy, systems and environmental strategies, and a community-based participatory approach that leverages resident knowledge, experience and priorities to guide change through participation and empowerment.

This project will enhance and expand current public health efforts in community-based strategies for obesity prevention by specifically and intensively focusing on neighborhoods within the

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1. CDC’s community level strategies for Obesity Prevention
2. Institute of Medicine’s recommended strategies for obesity prevention
3. Asset Based Community Development Model
geographic disparity areas of the city with the highest rates of chronic disease. The neighborhood focus of the strategies intends to increase ownership and adoption of the strategies within a context of local community scaled interventions. The project staff will include two Team Leaders (Management Analysts) and ten Neighborhood Liaisons (Health Program Specialists), which will each be assigned a target neighborhood in which to engage residents in the assessment, planning, implementation and evaluation of health improvement strategies for obesity prevention.

The project is structured in three phases of activity: Phase I: Community Selection and Assessment; Phase II: Resident Engagement; and Phase III: Implementation of Community Driven Interventions.

Phase I (Community Selection), will include the development of selection criteria to identify target area neighborhoods. The criteria will give higher priority to areas of health and socioeconomic disparities, and will also prioritize the presence of social networks. Phase I will also include the development of target area neighborhood health assessment reports. These reports will be compiled for each target area neighborhood and will include health and socioeconomic data for the population within the target area.

Phase II (Resident Engagement) will include the development of a neighborhood engagement process based on the principles of Asset Based Community Development. The process will incorporate the following five principles: the mapping of individual, community, and organizational assets; building relationships among local assets; mobilizing the local assets for health improvement and information sharing; convening a broad representation from the community to build a community vision and plan; and leveraging activities, investments and resources from outside the community to support community driven health improvement. Once the community engagement process is established, the recruitment and formation of resident leadership groups will take place. The purpose of these groups will be to increase participation and engagement from residents in chronic disease prevention initiatives.

Phase III (Implementation of Community Driven Interventions) will allow the resident leadership groups to identify and select evidence based obesity and chronic disease prevention strategies from among the CDC and IOM recommended approaches within the target area. The resident leadership groups will utilize consensus building methods to make decisions. The programs and initiatives will be focused on reducing obesity by increasing the proportion of adults who engage in regular physical activity and increasing the proportion of adults who consume the recommended amount of fruits and vegetables.

Throughout the three phases technical assistance, program documentation, and continuous quality improvement activities will occur through a partnership with the ABCD Institute to assure fidelity to the model and to support ongoing program improvements to achieve high levels of resident engagement and successful accomplishment of project health outcomes (BMI reduction).

Goals and Relationship to Regional Goals
Project Goals:
This project will work to improve the health status of residents and increase community member engagement in a neighborhood-based approach for chronic disease prevention.

This project meets the following regional goals:
This project addresses the RHP 6 need to provide improved prevention of chronic diseases including diabetes within the region (CN.2).

Challenges:
While ABCD methodologies have been proven effective in increasing resident engagement in chronic disease prevention, it represents a new approach for Metro Health to engage specific neighborhoods in identifying, planning, implementing and evaluation health promotion efforts.

To address these challenges in implementing this approach significant staff training and development has been planned for in the project implementation. Additionally, as interventions will be driven by resident priorities staff will seek to balance flexibility and responsiveness to community needs with consistency in timing and evaluation of health outcomes.

5-Year Expected Outcome for Provider and Patients:
Improved self-efficacy, knowledge and resources to support health among neighborhood residents. Improved healthy eating and physical activity levels in target neighborhoods. Reductions in BMI among residents leading to decreased risk of obesity-related chronic disease.

Starting Point/Baseline:
This project represents a new approach to health promotion planning and implementation. Therefore the baseline number of neighborhoods and participants begins at 0 in DY2.

Rationale:
San Antonio/Bexar County experiences a high death and disease burden related to chronic illnesses, with significant health disparities in diabetes and obesity within the urban core. In 2009, the five distinct leading causes of death in Bexar County for adults aged 25 and older were heart disease, malignant neoplasms, chronic lower respiratory diseases, cerebrovascular diseases, and diabetes mellitus (Metro Health, Health Profiles 2009). These causes accounted for 65% of all deaths in adults aged 25 and older, many of which can be attributed to unhealthy lifestyle behaviors related to poor nutrition, physical inactivity, and tobacco use. According to 2010 Behavioral Risk Factor Surveillance System (BRFSS) data, more than 67% of Bexar County respondents are overweight or obese, which includes disproportionate representation by African American and Hispanic residents. Approximately three-quarters of African American (72%) and Hispanic residents (76%) are overweight or obese, compared to 61% of Whites. Morbid obesity was reported in 20% of African Americans and 16% of Hispanics, but only 8% among Whites. Additional self-reported health status and behaviors according to the 2010 BRFSS found that 14% were diagnosed with diabetes, 28% are daily smokers, and only 22% consume five servings of fruits and vegetables per day, while 7% consume fruits and vegetables never or once daily. Access to fresh fruits and vegetables is limited in many locations. Fifty-seven percent of the individuals surveyed reported that there are no farmers markets in their community and 46% shop in small stores and corner stores, the majority of which do not sell any fresh fruits or vegetables. In terms of physical activity, 73% reported that they had participated in some...
physical activity during the past month. Most (84%) reported that there are sidewalks in their neighborhood, while only 36% reported that there were walking trails in their neighborhoods. Over one-third of the respondents stated that lack of time and motivation were the reasons that respondents gave for not walking. As with the local obesity demographics, there are significant income and geographic disparities for those diagnosed with diabetes. Diabetes was also found to be highest among those making less than $15,000 per year (21%) as compared to other income categories (ranging from 5-17%), with the highest incidence within the south, east and west sides of the inner city. Within Bexar County, Hispanics have twice the rate of diabetic amputations compared to white non Hispanics (117 vs. 54 per 100,000). These socioeconomic, racial and ethnic disparities in disease burden and complication rates are reflective of the gaps in linguistically and culturally appropriate community-based preventive services for chronic disease and diabetes that exists in San Antonio.

As a public health agency it is appropriate that Metro Health focus on primary prevention and community based strategies, consistent with CDC evidence-based strategies, to address obesity and obesity-related chronic diseases. The Neighborhood Based Physical Activity and Health Promotion Project will allow Metro Health and its partners to target resources and programs within the most vulnerable communities/neighborhoods, and capitalize on resident assets and engagement to drive decision making. This approach will focus on increasing opportunities for physical activity and healthy eating by allowing community members to fully engage in deciding what approach will work best within their neighborhood.

Racial and socioeconomic health disparities are presented in sharpest focus in the neighborhoods where low-income families and racial minorities live, and this project intends to improve the contexts within these neighborhoods and resultant effects on obesity. The higher rates of obesity and chronic disease in these areas are a direct consequence of lack of safe and public space and opportunities for physical activity in the physical environment, reduced access to healthy food resources, and levels of social capital that often are in short supply. Individuals that perceive their neighborhoods to be unsafe report lower levels of physical activity, especially racial minority adults and the elderly. Residents in poor neighborhoods would likely participate in more physical activity and walking in their neighborhoods if measures were taken to increase safety in those areas. Furthermore, children whose parents felt the neighborhood was unsafe had an increased tendency towards obesity by age seven. An increase of social cohesion has direct effect on criminal behavior within neighborhoods, as “close knit” communities where there is trust between neighbors have been shown to be more apt to organize in union against crime. Likewise, communities with strong social union are also more successful in advocating

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for their collective well being, such as fighting for improved services and resources, such as sidewalks and access to stores that sell healthy food. Lack of availability of healthy choices at corner stores and limited transportation to larger grocery stores affect minority communities tremendously in terms of chronic disease health outcomes. Metro Health has a proven track record on increasing access to healthy foods at the community level, namely through our healthy corner store initiative and healthy menu labeling initiative at restaurants. The project will increase our efforts to promote healthy eating using these or other evidence-based strategies in the target neighborhoods. The increase in social capital that asset-based community development promotes can have a positive effect on the acceptance of preventive health and health promotion measures within a community by building upon trust and also exerting positive social pressures.

Unique community need identification number the project addresses:
This project addresses the RHP 6 need to provide improved prevention of chronic diseases including diabetes within the region (CN.2).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The Neighborhood Based Physical Activity and Health Promotion Project represents a new strategic approach by Metro Health to focus chronic disease prevention efforts in small geographic areas disproportionately affected by health disparities. This approach represents a departure from more typical community wide or large area public health interventions. Metro Health intends to leverage resident engagement at the outset of the planning process in order to allow residents to lead decision making. In an effort to maximize resident engagement, Metro Health will recruit and hire the project staff from the health disparity areas within the community.

Related Category 3 Outcome Measure(s):

<table>
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<th>OD – 12 Primary Care and Primary Prevention</th>
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<tbody>
<tr>
<td>IT – 12.6 – Other Outcome Improvement Target – increase the % of adults who consume the recommended amount of fruits and vegetables</td>
</tr>
<tr>
<td>IT – 12.6 – Other Outcome Improvement Target – increase in % of adults who are physically active</td>
</tr>
<tr>
<td>IT – 12.6 – Other Outcome Improvement Target – Decrease the % of adults that are overweight or obese (BMI&gt;25)</td>
</tr>
</tbody>
</table>


### Reasons/rationale for selecting the outcome measures:
The outcome measures for the *Neighborhood Based Physical Activity and Health Promotion Project* include increasing the proportion of adults who engage in regular physical activity, and increasing the proportion of adults who consume the recommended amount of fruits and vegetables. These indicators will be measured using the Behavior Risk Factor Surveillance System (BRFSS) survey.

In addition to the oversampling done in intervention neighborhoods for this project the BRFSS is administered by the Centers for Disease Control and Prevention (CDC) on an annual basis. BRFSS is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States annually since 1984. The availability of county wide data and historical data will provide important opportunities to compare intervention neighborhood outcomes with those of the community as a whole over time.

These specific outcome measures were selected because they represent significant risk factors for several chronic diseases, and if impacted can help accelerate prevention of obesity-related chronic diseases such as diabetes and cardiovascular disease within the target neighborhoods. Increasing physical activity and fruit and vegetable consumption within the target neighborhoods and decreasing BMI have been shown effective in decreasing chronic disease rates.

### Relationship to other Projects:
The *Neighborhood Based Physical Activity and Health Promotion Project* and Metro Health’s Community Diabetes Program (Category 2 project: 091308902.2.3) intend to work in tandem within 10 target area neighborhoods to address health disparities. This project will focus on a primary prevention strategy to improve health behaviors and reduce obesity while the Community Diabetes Program will focus on secondary and tertiary prevention of a critical obesity-related chronic disease. The staff members within the two projects will work together to capitalize on the connections made within the neighborhoods, and will utilize the asset based community development model to build neighborhood level community support systems for individuals impacted by chronic disease.

### Relationship to Other Performing Providers’ Projects in the RHP:
This project does not appear to have a direct relationship to other RHP 6 projects but opportunities may arise to collaborate as specific neighborhood health priorities and needs are identified.

### Plan for Learning Collaborative:
Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 3, 6, 8 and 10 beginning in DY2. Additionally Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.

Metro Health will participate in the establishment of Learning Collaboratives to support and encourage information sharing and technical assistance related to obesity prevention, increasing opportunities for physical activity, improving the built environment, and increasing neighborhood engagement. The Learning Collaborative will allow Metro Health to share...
experiences and best practices with other providers in Bexar County and surrounding counties. Metro Health can assist in creating the Learning Collaborative, establishing goals and communication strategies, organizing events for information sharing, and adopting metrics to measure success.

Project Valuation:
Many of the demographic risk factors associated with chronic disease as well as high burdens of chronic disease morbidity and mortality are concentrated in neighborhoods within San Antonio and Bexar County that have traditionally lacked infrastructure to support healthy living and experienced higher rates of poverty. The approach that Metro Health will take in the Neighborhood Based Physical Activity and Health Promotion Project will focus on providing a comprehensive neighborhood-based approach to chronic disease prevention. Ten specific target areas will be selected for this initiative that have significant risk factors for chronic disease, but more importantly have a network of community agency and resident engagement assets that will facilitate opportunities for health improvement over the four years of the initiative. While these communities may have community cohesion and identity, additional resources are necessary to address health disparities. Special consideration will be given to address populations and geographic areas within the county that experience a poorer health status than the general population. Each of the 10 target neighborhood areas will include approximately 26,500 residents and will each cover a small geographic area defined by neighborhood boundaries, and natural or physical boundaries. The neighborhood boundaries will be self-defined, with an average scale of 2 square miles. The implementation of evidence-based obesity prevention strategies and infrastructure improvements to the built environment (such as side walk improvements, bike routes, cross walks, lighting, walking trail expansion, park improvements, and increasing linkages) will benefit community safety and health by increasing opportunity and access for physical activity. These strategies and improvements will have an intended reach well beyond the target neighborhood boundaries, as migration between neighborhoods is expected. By allowing residents to prioritize, select, and be involved in planning the projects and initiatives though the resident engagement process, the community needs will be addressed. This will also increase community ownership of the projects, which will help to ensure successful implementation and sustainability.

Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following factors in assigning a value to this health promotion project: achievement of waiver goals, community need, project scope and the level of project investment.

- This project was ranked high on achievement of waiver goals given the high potential for improved and long-term change in neighborhoods that would support a reduction in obesity-related chronic diseases.
- This project was ranked high in regards to addressing a community need. Obesity and obesity-related chronic disease is consistently listed as the leading health and social concern in Bexar County and has been established as one of four key priorities for Metro Health. San Antonio and Bexar County have placed increasing emphasis on obesity prevention for children and adults through the SA2020 goals, Community Health Improvement Plan and the work of the Mayor’s Fitness Council. Additionally the ABCD model for designing and implementing specific interventions will further emphasize community needs in project activities.
This project was ranked high on project scope in that services will be broadly targeted to all residents and visitors to the 10 target neighborhoods, with potential for additional resident impact outside of the intervention area. This approach is supported by an increasingly strong evidence-base for policy, systems, and environmental change approaches to health promotion, and in particular obesity prevention.

This project was ranked high in regards to program investment driven by the broad scope of population-based project activities as well as the expense associated with permanent infrastructure elements to support long-term neighborhood transformation that are likely to be part of the policy, systems and environmental change strategies applied in the intervention neighborhoods.
<table>
<thead>
<tr>
<th>091308902.2.2 PASS 1</th>
<th>2.6.4</th>
<th>N/A</th>
<th><strong>2.6.4 IMPLEMENT OTHER EVIDENCE-BASED HEALTH PROMOTION PROGRAMS IN AN INNOVATIVE MANNER: NEIGHBORHOOD BASED PHYSICAL ACTIVITY AND HEALTH PROMOTION</strong></th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>San Antonio Metropolitan Health District</td>
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<tr>
<td>Related Category 3</td>
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<td>TPI - 082426001</td>
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<tr>
<td>Outcome</td>
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<tr>
<td>Measure(s):</td>
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<tr>
<td>091308902.3.6</td>
<td>3.IT – 12.6</td>
<td>1.0</td>
<td>Other Outcome Improvement Target</td>
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<td>091308902.3.7</td>
<td>3.IT – 12.6</td>
<td>1.0</td>
<td>Other Outcome Improvement Target</td>
</tr>
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<td>091308902.3.8</td>
<td>3.IT – 12.6</td>
<td>1.0</td>
<td>Other Outcome Improvement Target</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
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<tr>
<td>[P-X]: Expand Staff and Partner Capacity to utilize Asset Based Community Development approaches</td>
<td></td>
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</tr>
<tr>
<td>Metric 1 [P-X-1]: Establish agreement with partner to provide technical assistance and training to Metro Health project staff and community partners in ABCD approaches</td>
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<tr>
<td>Goal: Establish agreement</td>
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<tr>
<td>Data Source: MOA or Contract</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,196,794.33</td>
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<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
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<tr>
<td><strong>Milestone 4</strong></td>
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<tr>
<td>[P-X]: Development of evidence based projects for targeted populations based on distilling the needs assessment and determining priority of obesity prevention strategies for the community</td>
<td></td>
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<tr>
<td>Metric 1 [P-X-1]: Conduct health status assessments and create neighborhood health profiles for each target neighborhood. Goal: 10 neighborhood profiles</td>
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<tr>
<td>Data Source: Population health indicators (BRFSS, YRBS, Census, Hospital Discharge Data)</td>
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<tr>
<td>Milestone 2 [P-X-2]: Establish resident driven intervention plans for each target</td>
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<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Milestone 7</strong></td>
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<tr>
<td>[I-6]: Identify residents in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6-1]: Number of residents participating in community engagement processes (ABCD) Goal: 100 participants</td>
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<tr>
<td>Data Source: Program records</td>
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<tr>
<td>Metric 2 [I-6-2]: Number of residents participating in health promotion/obesity prevention programs Goal: 400 participants</td>
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<tr>
<td>Data Source: Program records</td>
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<tr>
<td>Milestone 7 Estimated Incentive Payment:</td>
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<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<tr>
<td><strong>Milestone 9</strong></td>
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<tr>
<td>[I-6]: Identify residents in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6-1]: Number of residents participating in community engagement processes (ABCD) Goal: 100 participants</td>
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<tr>
<td>Data Source: Program records</td>
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<tr>
<td>Metric 2 [I-6-2]: Number of residents participating in health promotion/obesity prevention programs Goal: 400 participants</td>
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<tr>
<td>Data Source: Program records</td>
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<tr>
<td>Milestone 9 Estimated Incentive Payment:</td>
<td></td>
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<tr>
<td>Metric 1 [P-X-1]: Target area neighborhoods identified. Baseline/Goal: 10 target neighborhoods identified. Data Source: Map of neighborhood boundaries and population demographic summary.</td>
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<td>-------------------------------------------------------------</td>
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<tr>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $1,196,794.33</td>
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</table>

**Milestone 3**  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

<table>
<thead>
<tr>
<th>Metric 1 [P-6-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in collaborative meetings/calls. Data Source: Program records</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4</strong> Estimated Incentive Payment: $1,248,516.66</td>
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</table>

**Milestone 5**  
[I-6]: Identify residents in defined population receiving innovative intervention consistent with evidence-based model.

<table>
<thead>
<tr>
<th>Metric 1 [I-6-1]: Number of residents participating in community engagement processes (ABCD) Goal: 50 participants Data Source: Program records</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 6</strong> Estimated Incentive Payment: $1,892,131.50</td>
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</table>

**Milestone 7**  
[I-6]: Identify residents in defined population receiving innovative intervention consistent with evidence-based model.

<table>
<thead>
<tr>
<th>Metric 2 [I-6-2]: Number of residents participating in health neighborhood utilizing evidence-based community strategies for obesity prevention. Goal: 10 neighborhood intervention plans. Data Source: Program plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 8</strong> [P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 1 [P-6-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in collaborative meetings/calls. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 9</strong> Estimated Incentive Payment: $1,935,684.50</td>
</tr>
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</table>

**Milestone 10**  
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

<table>
<thead>
<tr>
<th>Metric 1 [P-6-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in collaborative meetings/calls. Data Source: Program records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes</td>
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</tr>
<tr>
<td>Metric 2 [P-6-2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $1,196,794.33</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment: $1,892,131.50</td>
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</tbody>
</table>
challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 6
Estimated Incentive Payment: $1,248,516.66

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $3,590,383</th>
<th>Year 3 Estimated Milestone Bundle Amount: $3,745,550</th>
<th>Year 4 Estimated Milestone Bundle Amount: $3,784,263</th>
<th>Year 5 Estimated Milestone Bundle Amount: $3,871,369</th>
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<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $14,991,565</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $14,991,565</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $14,991,565</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $14,991,565</td>
</tr>
</tbody>
</table>
Identifying Project and Provider Information:

Title: 2.6.2 Establish self-management programs and wellness using evidence-based designs: Community Diabetes Project
Unique RHP ID#: 091308902.2.3 - PASS 1
Provider Name: San Antonio Metropolitan Health District
TPI: 082426001

Project Summary:

Provider Description: The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals.

Intervention(s): The San Antonio Metropolitan Health District (Metro Health) will implement the Community Diabetes Project, that will expand access to the Stanford Chronic Disease Self Management and Diabetes Self Management Programs for individuals living with diabetes and their family members/caregivers as well as those that are at risk for developing diabetes. The Stanford Chronic Disease Self Management and Diabetes Self Management Programs are staff intensive six–week long, two and a half hours per week process driven workshops that are meant to build patients’ self-efficacy in managing their conditions. The workshops are co-facilitated by two lay leaders with chronic conditions of their own, with the intent on building peer support. The project aims to improve disease management outcomes by expanding the reach of its current chronic disease self management program through increasing the number of locations and courses offered as well as to increase the number of certified lay-leaders and trainers throughout the community, with the goal of improving the physical and emotional health of participants while reducing health care costs in targeted neighborhoods with the highest incidence of chronic disease. Metro Health will also establish a sub-contract with the YMCA of Greater San Antonio to implement diabetes prevention intervention and education courses across the community. With support and training from YMCA of the USA, the YMCA of Greater San Antonio will replicate the National YMCA Diabetes Prevention Program (YDPP). YDPP helps those at high risk of developing type-2 diabetes adopt and maintain healthy lifestyles by eating healthier, increasing physical activity, and losing a modest amount of weight. The YDPP has a 12-month duration, which begins with an intensive 16 weekly core sessions and is followed by 8 months of monthly maintenance sessions. Together, these positive changes help reduce their chances of developing the disease. The YMCA also implements the parallel program Y Living for those who do not meet the clinical eligibility for YDPP but are diagnosed with or at risk for chronic disease. This program will also be utilized for those individuals referred but ineligible for YDPP.

Need for the project: San Antonio/Bexar County experiences a high death and disease burden related to chronic illnesses, with significant health disparities in diabetes and its complications. These socioeconomic, racial and ethnic disparities in disease burden and complication rates are reflective of the gaps in linguistically and culturally appropriate community-based preventive services for chronic disease and diabetes that exists in San Antonio. The proposed interventions

1036 ★ RHP 6 Plan ★ March 8, 2013
San Antonio Metropolitan Health District
will fill those gaps in community-based preventive services and provide expanded services more in line with community demand for services and disease burden in San Antonio.

**Target population:** The *Community Diabetes Project* will be provided throughout the city of San Antonio, with an emphasis on neighborhoods within the central urban core which has a high burden of diabetes and prediabetes within geographic disparity areas. These areas correspond with those sectors of the city with higher percentages of minorities (Hispanic and African American), low educational attainment and household income, along with high rates of uninsured or underinsured.

**Category 1 or 2 expected patient benefits:** This project will work to improve self-efficacy for managing or preventing diabetes, improved health behaviors and reduced health care utilization and costs among program participants and their caretakers by increasing availability of evidence-based disease self-management programs and provide the National YMCA Diabetes Prevention Program (YDPP) at multiple locations throughout the city. 1700 participants per year will be served by the two interventions for a total of at least 5100 participants over the waiver term.

**Category 3 outcomes:**

<table>
<thead>
<tr>
<th>OD-1 Primary Care and Chronic Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>o IT- 1.10 - Diabetes Care: HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td>OD – 9 Right Care, Right Setting</td>
</tr>
<tr>
<td>o IT – 9.2 – ED Appropriate Utilization (reduce ED visits for Diabetes)</td>
</tr>
<tr>
<td>OD – 10 Quality of Life and Functional Status</td>
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<tr>
<td>o IT – 10.7 – Other Outcome Improvement Target – Improve Self-Reported Health Status</td>
</tr>
</tbody>
</table>

**Project Description:**

**Project Overview**

The San Antonio Metropolitan Health District (Metro Health) aims to expand access to the Stanford Chronic Disease Self Management and Diabetes Self Management Programs for individuals living with diabetes and their family members/caregivers as well as those that are at risk for developing diabetes. Ultimately, the project aims to improve disease management outcomes by expanding the reach of its current chronic disease self management program through increasing the number of locations and courses offered as well as to increase the number of certified lay-leaders and trainers throughout the community.

Metro Health will also establish a sub-contract with the YMCA of Greater San Antonio to implement diabetes prevention intervention and education courses across the community. With support and training from YMCA of the USA, the YMCA of Greater San Antonio will replicate the National YMCA Diabetes Prevention Program (YDPP) at eighteen locations. YDPP helps those at high risk of developing type-2 diabetes adopt and maintain healthy lifestyles by eating healthier, increasing physical activity, and losing a modest amount of weight. Together, these positive changes help reduce their chances of developing the disease. YDPP is based on research funded by the National Institutes of Health and the Centers for Disease Control and Prevention. The YMCA also implements the parallel program Y Living for those who do not meet the clinical eligibility for YDPP but are diagnosed with or at risk for chronic disease. This program will also be utilized for those individuals referred but ineligible for YDPP.
The Stanford Chronic Disease and Diabetes Self-Management Programs were developed and evaluated over the past 30 years at the Stanford University School of Medicine’s Patient Education Center. Stanford has developed and offered programs that have been tested for effectiveness through randomized, controlled trials that are funded by research grants and span two to five years. Their programs are not licensed for use outside of Stanford unless they are proven through rigorous research standards to be evidenced-based. The aim of their research-driven programs is to improve the physical and emotional health of participants while reducing health care costs.

Expanded staff capacity can train many additional lay leaders to hold Stanford Chronic Disease and Diabetes Self-Management workshops within their own communities and to their peer groups, making it possible to reach many more of the neighborhoods that experience the highest rates of disease burden. Both staff and community lay leaders will facilitate the six-week, two and a half hour long workshops, in addition to a two hour session added at the week before the workshop for biometric data collection and registration. Community lay leaders will be recruited from targeted neighborhoods with the highest incidence of chronic disease, and will facilitate self-management workshops within these neighborhoods along with expanded Metro Health staff. Metro Health staff will supplement the chronic disease and diabetes self-management workshops with specialized outreach and preventive education on the complications of diabetes to include heart disease, kidney disease, neuropathy, and eye complications. Metro Health staff will also establish a referral system to appropriate community-based lifestyle interventions for all participants and caregivers that go through the workshops. They will receive intensive training on health disparities and the social determinants of health as related to the communities in which they work. Preference will be given in hiring staff that is reflective of the socioeconomic, racial, and ethnic diversity of intervention communities.

The YMCA Diabetes Prevention Program (YDPP) has been shown to reduce the risk of developing type-2 diabetes by up to 58%. The success of the program was supported by the evidence based use of small group activities and Social Support Interventions. During the CDC’s Diabetes Prevention Program, the risk reduction was even greater—71%—among adults aged 60 years or older. The YMCA of Greater San Antonio will provide the YDPP at eighteen YMCA locations and affiliated community sites throughout San Antonio to include childcare sites, schools and churches. Participants in the YDPP gather regularly in small groups facilitated by a trained lifestyle coach. In small groups, participants discuss healthy eating, physical activity, and other behavior changes that, over the one-year course, will help reduce their risk of developing type-2 diabetes. In the supportive environment, individual activities are a primary component of the YDPP’s 12-month course. During 16 weekly core sessions and up to 8 months of maintenance sessions, individuals cover topics such as: healthy eating; getting started with physical activity; overcoming stress; and staying motivated. After the initial core sessions, participants meet monthly for added support in maintaining their progress for lifestyle behavior change.

**Goals and Relationship to Regional Goals**

**Project Goals:**
Ultimately, the project aims to improve disease management outcomes by expanding the reach of its current chronic disease self-management program through increasing the number of locations and courses offered as well as to increase the number of certified lay-leaders and trainers.
This project meets the following regional goals:
This project directly addresses the RHP 6 need to provide improved prevention and management of chronic diseases including diabetes within the region (CN.2).

**Challenges:**
San Antonio faces significant challenges with high number of diabetes, pre-diabetics and persons with poorly controlled diabetes.

This project represents a significant expansion of self-management activities by Metro Health and YDPP will be a new program to be implemented by the Greater YMCA of San Antonio. Both programs have a very strong evidence-base for improving outcomes among diabetics and pre-diabetes. Staff experience and support for both activities is high and should provide good support for program expansion.

**5-Year Expected Outcome for Provider and Patients:**
Improved self-efficacy for managing diabetes, improved health behaviors and reduced health care utilization and costs among program participants.

**Starting Point/Baseline:**
In the past two years Metro Health has increased internal capacity to provide Stanford Chronic Disease and Diabetes Self-Management programming in Bexar County. Staff have completed eighteen community-based workshops of seven weeks in lengths, reaching 192 total participant workshop completers and contacts of over 1,300 community members with or at risk of chronic disease, diabetes, and their caretakers/family members. These workshops have taken place in churches, community centers, and senior centers. In a local environment with limited community- based and culturally sensitive preventive services, geographic areas of pronounced chronic disease and diabetes disparities, and a primary care and patient-centered medical home shortage in the inner city. These services have been supported by state grant funds which will expire in March 2013.

The YMCA of Greater San Antonio is presently not offering the YDPP program but is gearing up for the insurance- based arm of YDPP in partnership with United Healthcare in the coming months. This proposed project would provide access to an effective intervention in a community- based setting for at- risk uninsured and underinsured individuals to prevent the onset of diabetes.

**Rationale:**
Bexar County experiences a high death and disease burden related to chronic illnesses. There is a significant need for evidence-based disease self-management programs offered within community settings at no cost to participants.

In 2009, the five distinct leading causes of death in Bexar County for adults aged 25 and older were heart disease, malignant neoplasms, chronic lower respiratory diseases, cerebrovascular diseases, and diabetes mellitus (Metro Health, Health Profiles 2009). These causes accounted for 65% of all deaths in adults aged 25 and older, many of which can be attributed to unhealthy lifestyle behaviors related to poor nutrition, physical inactivity, and tobacco use. According to 2010 Behavioral Risk Factor Surveillance System (BRFSS) data, more than 67% of Bexar County respondents are overweight or obese, which includes disproportionate representation by
African American and Hispanic residents. Approximately three-quarters of African American (72%) and Hispanic residents (76%) are overweight or obese, compared to 61% of Whites. Morbid obesity was reported in 20% of African Americans and 16% of Hispanics, but only 8% among Whites. Additional self-reported health status and behaviors according to the 2010 BRFSS found that 14% were diagnosed with diabetes, 28% are daily smokers, and only 22% consume five servings of fruits and vegetables per day, while 7% consume fruits and vegetables never or once daily. In terms of physical activity, 73% reported that they had participated in some physical activity during the past month. Over one-third of the respondents stated that lack of time and motivation was the reasons that respondents gave for not walking. As with the local obesity demographics, there are significant income and geographic disparities for those diagnosed with diabetes. Diabetes was also found to be highest among those making less than $15,000 per year (21%) as compared to other income categories (ranging from 5-17%), with the highest incidence within the south, east and west sides of the inner city. Within Bexar County, Hispanics have twice the rate of diabetic amputations compared to white non Hispanics (117 vs. 54 per 100,000). These socioeconomic, racial and ethnic disparities in disease burden and complication rates are reflective of the gaps in linguistically and culturally appropriate community-based preventive services for chronic disease and diabetes that exists in San Antonio.

**Unique community need identification number the project addresses:**
This project directly addresses the RHP 6 need to provide improved prevention and management of chronic diseases including diabetes within the region (CN.2).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
The proposed intervention to increase availability of evidence-based disease self-management programs and provide the National YMCA Diabetes Prevention Program (YDPP) at multiple locations throughout the city will fill those gaps in community-based preventive services and provide expanded services more in line with community demand for services and disease burden in San Antonio. The health educators and community-based lay leaders will complete eighty-eight Stanford Chronic Disease and Diabetes Self-Management Workshops throughout the city with an emphasis on disparity areas. These workshops will reach over 1320 individual participants with 7,392 individual contacts. Community capacity to provide disease self-management workshops will be increased to 24 lay leaders, and their retention will be aided in the provision of a small stipend. The YMCA of Greater San Antonio will provide 36 sixteen week intensive lifestyle intervention programs at the community level to reach over 500 individuals and their families who are at risk of developing diabetes.

**Related Category 3 Outcome Measure(s):**

**OD-1 Primary Care and Chronic Disease Management**

IT- 1.10 - Diabetes Care: HbA1c poor control (>9.0%)

**OD – 9 Right Care, Right Setting**

IT – 9.2 – ED Appropriate Utilization (reduce ED visits for Diabetes)

**OD – 10 Quality of Life and Functional Status**
Reasons/rationale for selecting the outcome measures:
The Category 3 Outcome Measures selected for the community diabetes project are Hemoglobin A1c poor control (9.0%); reduced emergency department visits related to diabetes; and improved self-reported overall health status. Participants in the Stanford University Self-Management Programs and YMCA Diabetes Prevention Program participants will be assessed for these metrics at baseline and at six and twelve months. HbA1c in poor control is associated with increased incidence of the complications from diabetes, including but not limited to cardiovascular disease, nephropathy, neuropathy, and retinopathy. As HB A1c measures average plasma glucose concentration over prolonged periods of time, it is a more accurate indicator of average blood glucose levels in the months prior to the test.

Emergency Department visits will be assessed at baseline and at six and twelve months for all program participants using validated questions that have been used in Stanford program evaluations. Enhanced self-efficacy, improved communication with healthcare providers and social supports will result in lowered percentages in diabetes related emergency department visits for all participants, which is vital in a population with high healthcare costs. Improved community based education on the primary and secondary prevention of diabetes and its complications will reduce utilization and associated costs by promoting lifestyle interventions (YDPP Program) and patient-empowerment in the primary healthcare setting (Stanford Self-Management Programs).

Finally, overall self-reported health status will be assessed among participants in both programs at baseline, six months and twelve months. While this is a general reflection of health rather than specific to diabetes, it will encompass changes associated with both the Stanford and YDPP curricula including nutritional changes, physical activity, self-efficacy and other components. Additionally Stanford DMSMP research has found this item to be a strong predictor of future health. The wording from the Behavioral Risk Factor Surveillance Survey will be used to allow for comparisons to community wide data collected for Bexar County.

Relationship to other Projects:
The expansion of the Stanford Chronic Disease Self Management and Diabetes Self Management Programs and new provision of the YMCA Diabetes Prevention Program (YDPP) at the community-level throughout San Antonio will work in concert with and enhance Metro Health’s proposed Neighborhood Based Physical Activity and Health Promotion Project (Category 2 project: 091308902.2.2) by building neighborhood level community support systems for individuals living with chronic disease, diabetics, and individuals and families at risk of developing diabetes.

Relationship to Other Performing Providers’ Projects in the RHP:
Metro Health will coordinate community-based self-management and chronic disease prevention programs with regional partners including University Health System’s diabetes registry project, the UTHSCSA’s chronic care management and community health worker projects.
Plan for Learning Collaborative:

Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 2, 4, 6 and 8 beginning in DY2. Additionally, Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.

Project Valuation:

Bexar County hospital discharge data estimated that hospitalizations directly related to diabetes in 2009 accounted for $100 million in costs, which excludes care for emergency room visits that did not result in hospitalization, as well as frequency of doctor visits. Overall, San Antonio as a community bears a very heavy economic toll from diabetes when indirect costs such as disability from complications, work loss, and premature death from related complications are taken into account.

This proposed project will reach at least 5100 individuals and involves a significant time commitment of project staff and participants in each cohort. The Stanford Chronic Disease Self Management and Diabetes Self Management Programs are staff intensive six –week long, two and a half hours per week process driven workshops that are meant to build patients’ self-efficacy in managing their conditions. The workshops are co-facilitated by two lay leaders with chronic conditions of their own, with the intent on building peer support. The YDPP has a 12-month duration, which begins with an intensive 16 weekly core sessions and is followed by 8 months of monthly maintenance sessions.

Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following factors in assigning a value to this health promotion project: achievement of waiver goals, community need, project scope and the level of project investment.

- This project was ranked high on achievement of waiver goals given the strong research and high potential for reduction of healthcare costs associated with diabetes prevention and management for Medicaid and other underserved populations in Bexar County.
- This project was ranked moderately in regards to addressing a community need. While diabetes in particular, and chronic diseases in general, are high priority community health issues, this project focuses more on secondary and tertiary prevention rather than primary prevention relative to other proposed Metro Health projects.
- This project was ranked moderately on project scope in that services will be widely available to residents but the number of participants in both the Stanford and YDPP groups will be limited by class capacity rather than impacting the broader community.
- This project was ranked moderately in regards to program investment since the interventions require ongoing participant interaction and evaluation over a somewhat extended period of time even though the per episode cost of the intervention is conservative.
<table>
<thead>
<tr>
<th>091308902.2.3</th>
<th>2.6.2</th>
<th>N/A</th>
<th>2.6.2 ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS: COMMUNITY DIABETES PROJECT</th>
</tr>
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<tbody>
<tr>
<td>PASS 1</td>
<td></td>
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<td>San Antonio Metropolitan Health District TPI - 082426001</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>091308902.3.9</td>
<td>091308902.3.10</td>
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<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
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<tr>
<td><strong>Milestone 1</strong> [P-X]: Expand Stanford Chronic Disease Self-Management Program</td>
<td><strong>Milestone 4</strong> [P-X]: Expand Community capacity for Stanford Chronic Disease Self-Management Program using lay leaders</td>
<td><strong>Milestone 8</strong> [I-6]: Implement Stanford Chronic Disease Self-Management Program</td>
<td><strong>Milestone 11</strong> [I-6]: Implement Stanford Chronic Disease Self-Management Program</td>
</tr>
<tr>
<td>Metric 1 [P-X.1]: Obtain a specialized multi-year license from Stanford Self-Management Programs Baseline/Goal: License obtained Data Source: License</td>
<td>Metric 1 [P-X.1]: Train lay leaders to conduct Stanford Chronic Disease Self-Management Courses Goal: 24 lay leaders trained Data Source: Training certificates</td>
<td>Metric 1 [I-6.1]: Number of participants enrolled in Stanford Chronic Disease Self-Management Course Goal: 1200 participants Data Source: Program Participation Logs, Enrollment forms</td>
<td>Metric 1 [I-6.1]: Number of participants enrolled in Stanford Chronic Disease Self-Management Course Goal: 1200 participants Data Source: Program Participation Logs, Enrollment forms</td>
</tr>
<tr>
<td>Metric 2 [P-X.21]: Train Metro Health project staff as Stanford lay leaders in the Stanford Self-Management Programs Baseline/Goal: All project staff trained Data Source: Training Logs</td>
<td><strong>Milestone 5</strong> [I-6]: Implement Stanford Chronic Disease Self-Management Program</td>
<td><strong>Milestone 9</strong> [I-6]: Implement YDPP Program</td>
<td><strong>Milestone 12</strong> [I-6]: Implement YDPP Program</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $655,471.50</td>
<td>Milestone 5 Estimated Incentive Payment: $882,995.00</td>
<td>Milestone 9 Estimated Incentive Payment: $903,319.33</td>
<td>Milestone 12 Estimated Incentive Payment: $903,319.33</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $837,755.66</td>
<td>Milestone 8 Estimated Incentive Payment: $882,995.00</td>
<td>Milestone 11 Estimated Incentive Payment: $903,319.33</td>
<td>Milestone 12 Estimated Incentive Payment: $903,319.33</td>
</tr>
</tbody>
</table>
### Milestone 2
[P-X]: Establish YDPP program

**Metric 1 [P-X.1]:** Establish contract with YMCA to conduct YDPP program
*Baseline/Goal:* Establish contract and initiate YDPP
*Data Source:* Contract

**Milestone 2 Estimated Incentive Payment:** $837,755.66

### Milestone 3
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-6.1]:** Number of participants enrolled in YDPP/Y Living
*Goal: 500 participants*
*Data Source:* Program Participation Logs, Enrollment forms

**Milestone 6 Estimated Incentive Payment:** $655,471.50

### Milestone 6
[I-6]: Implement YDPP Program

**Metric 1 [I-6.1]:** Number of participants enrolled in YDPP/Y Living
*Goal: 500 participants*
*Data Source:* Program Participation Logs, Enrollment forms

**Milestone 9 Estimated Incentive Payment:** $882,995.00

### Milestone 10
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-6.1]:** Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.
*Baseline/Goal:* Participate in collaborative learning around shared or similar projects.
*Data Source:* Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes

**Metric 2 [P-6.2]:** Share challenges and solutions

**Milestone 12 Estimated Incentive Payment:** $903,319.33

### Milestone 13
[P-6]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-6.1]:** Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.
*Baseline/Goal:* Participate in collaborative meetings/calls.
*Data Source:* Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes

**Metric 2 [P-6.2]:** Share challenges and solutions

**Milestone 12 Estimated Incentive Payment:** $903,319.33
webinars including agendas for phone calls, slides from webinars, and/or meeting notes

**Metric 2 [P-6.2]**: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 3 Estimated Incentive Payment: $837,755.66

Milestone 10 Estimated Incentive Payment: $882,995.00

**Year 2 Estimated Milestone Bundle Amount:** $2,513,267

**Year 3 Estimated Milestone Bundle Amount:** $2,621,886

**Year 4 Estimated Milestone Bundle Amount:** $2,648,985

**Year 5 Estimated Milestone Bundle Amount:** $2,709,958

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $10,494,096
### Identifying Project and Provider Information:

| Title: | 2.7.6 Implement other evidence-based disease prevention programs in an innovative manner: HIV and Syphilis Reduction in Bexar County |
| Unique RHP ID#: | 091308902.2.4 - PASS 2 |
| Performing Provider: | San Antonio Metropolitan Health District |
| Performing Provider TPI: | 082426001 |

### Project Summary:

**Provider Description:** The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals. The STD/HIV Branch serves individuals through STD surveillance, contact investigation and clinic services. Each year over 16,000 STD reports are submitted, over 8000 contact investigations are conducted and approximately 11,000 patient visits occur in the clinic.

**Intervention(s):** This project will focus on reducing HIV and Syphilis infections with a special focus on high risk populations in Bexar County. This project will utilize four components that will work in conjunction to support the project goal.

1. Develop and implement a new outreach unit to focus on education and screening in the field for HIV and Syphilis among high risk adults and adolescents (13 years of age or greater). This may include probation or drug treatment settings in addition to other geographic areas and settings identified through surveillance data.
2. Conduct clinical case management and case investigations of all high risk pregnant women to assure appropriate prenatal care and third trimester syphilis screening to prevent congenital syphilis cases and other STD transmission. High risk women are defined as any that present to the Metro Health STD clinic for any reason or that are referred to Metro Health STD surveillance staff by community physicians.
3. Conduct education and outreach to local medical providers to encourage the adoption of third trimester syphilis testing among all pregnant women in Bexar County.
4. Expand STD clinic capacity (hours and/or staff per shift) to receive additional patients identified through community outreach activities and provide prompt and appropriate screening and treatment for syphilis and other sexually transmitted diseases.

**Need for the project:** San Antonio has several challenges and a critical need for enhanced, targeted HIV and syphilis prevention, control and treatment strategies. This will reduce the burden of sexually transmitted diseases and HIV and improve the health status of adolescents and adults 13 years of age and greater in San Antonio, Texas. The Bexar County rate of HIV infection is 21.2 per 100,000 population which is 1.25 times higher than the state rate of 16.9. Bexar County’s primary and secondary syphilis rate in 2011 was 2.3 times higher than the national and state rates. With 18 cases in 2012, the congenital syphilis rate in Bexar County was...

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75.3 per 100,000 live births, a rate far surpassing any recent year. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011).

Target populations: The target populations for this project include: high risk adults and adolescents (13 years of age or greater), high risk pregnant women, persons exposed or infected with HIV or Syphilis, and local medical providers. Of the patients currently seen in the STD Clinic, approximately 80% are either Medicaid eligible or indigent. We expect similar or higher numbers in the high risk targeted populations.

Category 1 or 2 expected patient benefits: The project’s goal is to screen 800 high risk persons per year for HIV and Syphilis, assure third trimester syphilis screening to prevent congenital syphilis, and provide coordination of clinical services for individuals that are identified as infected. Clinic services will be expanded by approximately 20% to see an additional 2000 clinic visits per year. In total this project is expected to support services to 8760 individuals.

Category 3 outcomes:
OD-12 Primary Care and Primary Prevention
- IT- 12.5 Other USPSTF Endorsed Screening Outcome Measure – HIV Screening in High Risk Adults and Adolescents
- IT- 12.5 Other USPSTF Endorsed Screening Outcome Measure – Syphilis Screening in High Risk Adults and Adolescents
- IT – 12.6 Other Outcome Improvement Target – Third Trimester Syphilis Screening in High Risk Women

Project Description:
Project Overview
San Antonio Metropolitan Health District (Metro Health) submits this proposal with the overall goal to reduce the burden of sexually transmitted diseases and HIV and improve the health status of adolescents and adults 13 years of age and greater in Bexar County, Texas.

Bexar County has several challenges and has a critical need for enhanced disease prevention and control strategies in an effort to promote and encourage long-term behavior changes in adolescents and adults 13 years of age and greater. This funding will support new strategies to address local communicable disease rates. These would include increasing clinical services in the STD clinic, expanding services to the field, adding case management to prevent congenital syphilis infections and conducting provider education. Additionally, targeted HIV and syphilis testing will be notably increased by funding staff that will provide screening, health education and risk reduction counseling.

In 2011, the overall rate of newly diagnosed HIV cases for Bexar County was 21.2 cases per 100,000, compared to a 2010 state rate of 16.9 per 100,000. This county rate is 25% higher than the state rate. Newly diagnosed HIV cases in Bexar Country disproportionately affect two minority populations: Hispanics and Non Hispanic African Americans. In Bexar County at the end of 2011, Metro Health reported 4,312 persons living with HIV infection; this is 263.7 cases per 100,000 people. The CDC estimates 20% of persons infected with HIV do not know their
status. Targeted HIV testing will identify and link these individuals to care, leading to the goal of decreasing community viral load, and interrupting the spread of HIV. Bexar County’s primary and secondary syphilis rate in 2011 was 2.3 times higher than the national and state rate. There was a 309% increase in primary and secondary syphilis cases, between the year 2002 and 2011 in the county. Additionally, disparities among racial/ethnic groups in Bexar County are deep, with the 2011 rate for non-Hispanic African Americans, the highest at 20.4, compared to 11.8 for Hispanics and 6.2 for the non-Hispanic Whites. Additionally, the number of Syphilis and HIV cases among youth ages 13-19 increased by 77% in Bexar County from 2006 to 2010. During the same period, reported cases of Chlamydia and Gonorrhea increased to 31% and 29% respectively for the same age group. Regarding congenital syphilis, since 2008, Bexar county’s congenital syphilis rate has increased. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011). In 2012, 18 cases of congenital syphilis were confirmed for a rate of 75.3 per 100,000 live births, a rate far surpassing any recent year.

This project will address these challenges with four components that will work in conjunction to support the project goal;

1. Develop and implement a new outreach unit to focus on education and screening in the field for HIV and Syphilis among high risk adults and adolescents (13 years of age or greater). This may include probation or drug treatment settings in addition to other geographic areas and settings identified through surveillance data.

2. Conduct clinical case management and case investigations of all high risk pregnant women to assure appropriate prenatal care and third trimester syphilis screening to prevent congenital syphilis cases and other STD transmission. High risk women are defined as any that present to the Metro Health STD clinic for any reason or that are referred to Metro Health STD surveillance staff by community physicians.

3. Conduct education and outreach to local medical providers to encourage the adoption of third trimester syphilis testing among all pregnant women in Bexar County. 81

4. Expand STD clinic capacity (hours and/or staff per shift) to receive additional patients identified through community outreach activities and provide prompt and appropriate screening and treatment for syphilis and other sexually transmitted diseases.

Goals and Relationship to Regional Goals

Project Goals:

1. Reduce HIV infections in high risk adults and adolescents (13 years of age or greater),

2. Reduce syphilis infections in high risk adults and adolescents (13 years of age or greater)

3. Reduce congenital syphilis infections

4. Increase the efficiency of treatment services by provision or referral for sexually transmitted diseases and HIV

This project meets the following regional goals:

This project directly addresses the RHP 6 need to address high rates of communicable diseases within the region (CN.6).

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**Challenges:**
Bexar County has several challenges and a critical need for enhanced, targeted HIV and syphilis prevention, control and treatment strategies. This will reduce the burden of sexually transmitted diseases and HIV and improve the health status of adolescents and adults 13 years of age and greater in Bexar County, Texas. Rates of HIV and syphilis infections increased in Bexar County, both are higher than the state and national levels. The Bexar County rate of HIV infection is 21.2 per 100,000 population which is 1.25 times higher than the state rate of 16.9. Bexar County’s primary and secondary syphilis rate in 2011 was 2.3 times higher than the national and state rates. With 18 cases in 2012, the congenital syphilis rate in Bexar County was 75.3 per 100,000 live births, a rate far surpassing any recent year. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas between for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011).

Metro Health will seek to address these significant community challenges through expanded and targeted HIV and Syphilis prevention efforts focused on high risk adults, adolescents and pregnant women.

**5-Year Expected Outcome for Provider and Patients:**
- increase in high risk adults and adolescents (13 years of age or greater) screened for HIV infection
- increase in high risk adults and adolescents (13 years of age or greater) screened for Syphilis infection
- increase in third trimester syphilis testing to prevent congenital syphilis

**Starting Point/Baseline:**
Currently the Metro Health STD/HIV Branch receives local, state and federal-pass through funding to support STD surveillance and case investigation activities. Additionally local funds provide support to operate the STD clinic for 32 hours each week. Funding is not currently available to expand clinic hours, expand field testing for high risk populations or conduct case management or education activities to support congenital syphilis prevention. This funding will expand the clinical services in the STD/HIV Branch and provide funding to support new STD prevention strategies among high risk populations. The clinic provides approximately 11,000 patient visits annually. The baseline for case management and provider education is zero. The STD Branch has periodically provided field testing for special events such as World AIDS day but does not have a routine field testing operation. However new grant funds have recently been awarded that will provide approximately 1100 HIV field tests annually. The services proposed under this project will provide additional high risk testing and include both HIV and syphilis testing.

**Rationale:**
Rates of HIV and syphilis infections increased across Bexar county, levels of which are higher than both the state and national level, for both conditions. From 2002-2011 there was a 309% increase in primary and secondary syphilis cases in Bexar County. There was a drop in HIV infections in 2010 to 281 new infections diagnosed in Bexar County; yet in 2011, the number jumped to 361 new HIV infections diagnosed, the highest in the past ten years. With 18 cases in 2012, the congenital syphilis rate in Bexar County was 75.3 per 100,000 live births, a rate far...
surpassing any recent year. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011).

One of the first steps to HIV and STD prevention is for the individual to know their status of infection—and that is accomplished with screening. The challenges that Bexar County faces with HIV and syphilis are the reasons why this project option was developed. Metro Health aims to reduce the rates of HIV and syphilis infection by focusing on targeted testing among residents of Bexar County, especially those adults and adolescents at high risk for infection of HIV and syphilis and high risk pregnant women in order to prevent congenital syphilis cases. The Centers for Disease Control and Prevention (CDC) has identified HIV infection as one of the “winnable battles” that can be won with evidence based strategies.82

Metro Health joins the battle against HIV infection and syphilis by developing a project with three major components: community-based HIV and Syphilis prevention, case management, and clinical services. These components were chosen so that the Bexar County community receives high quality, efficient, and effective prevention and clinical services to address the high rates of HIV and STD in the community. Outcomes, milestones, and metrics selected for this project not only address each of the three components, but they also help Metro Health monitor their efforts in achieving their outcomes. Such efforts also support the RHP 6 in controlling the spread of these diseases that are extremely preventable. Furthermore, Metro Health’s efforts in addressing HIV and syphilis infection rates helps strengthen the health care infrastructure, representing an option for Bexar county residents to gain access to quality care.

**Unique community need identification number the project addresses:**

Metro Health’s multipronged project addresses RHP 6 Community Need CN.6 through targeted HIV and syphilis testing and coordination of care. These actions serve as a safety net for providers in the region and allow the many uninsured or underinsured residents of Bexar County gain access to critical screening, case management and treatment services.

Sexual health has become a priority within Bexar County. In cooperation with the Health Collaborative, Metro Health has identified Sexual Health as one of the five data-driven health priorities through the 2010 Bexar County Community Health Improvement Plan (CHIP). The sexual health goal is to “ensure that males and females have access to education and resources to promote sexual health.” Additionally specific objectives identified in the CHIP include decreasing the rate of syphilis, congenital syphilis and HIV and increasing the rates of HIV testing.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

Through innovative strategies, Metro Health is proactive in connecting with these hard-to-reach and hard-to-find individuals. This project will significantly enhance existing delivery systems. The unique way in which Metro Health will accomplish this is through linkages with the three existing areas of the STD/HIV program: Surveillance, Disease Intervention, and Clinic. Targeted HIV and syphilis testing will be notably increased by funding staff that will

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provide screening, health education and risk reduction counseling. This funding will also support specific efforts to reduce the incidence of congenital syphilis through case management and provider outreach. The new HIV/Syphilis Prevention team will collaborate with the HIV/STD Disease Intervention team, the HIV/STD Surveillance team, and the Clinical team through monthly meetings about disease trends, new locations for holding screenings, and enhancing the coordination of care for clients seen in the clinic. This coordination will allow project staff to focus outreach and testing strategies on “real time” disease trends; it will also significantly enhance the clinic’s ability to serve more people and serve them more efficiently. Overall it is expected that 2920 individuals will receive new services each year (DY3-DY5) for a total of 8760 over the course of the project.

**Related Category 3 Outcome Measure(s):**

**OD-12 Primary Care and Primary Prevention**

IT- 12.5 Other USPSTF Endorsed Screening Outcome Measure – HIV Screening in High Risk Adults and Adolescents  
IT- 12.5 Other USPSTF Endorsed Screening Outcome Measure – Syphilis Screening in High Risk Adults and Adolescents  
IT – 12.6 Other Outcome Improvement Target – Third Trimester Syphilis Screening in High Risk Women

**Reasons/rationale for selecting the outcome measures:**

The Metro Health comprehensive strategy for this STD and HIV prevention project has three Category 3 Outcomes. 1) Increase in high risk adults and adolescents (13 years of age or greater) screened for HIV infection 2) increase in high risk adults and adolescents (13 years of age or greater) screened for Syphilis infection and 3) increase in pregnant women screened for syphilis during the third trimester. Additional healthcare costs and negative social outcomes will be averted by preventing and controlling the spread of HIV and Syphilis infections in Bexar County, including significant clinical and developmental issues associated with congenital syphilis infection.

These Metro Health outcomes are a priority for the RHP as supported by local STD and HIV data. Bexar County’s primary and secondary syphilis rate in 2011 was 2.3 times higher than the national and state rate. Bexar County’s rate of new HIV infections in 2011, 21.2 cases/100,000 population, was 1.3 times the state rate of 16.9. This county experienced a 27% increase in new HIV infections diagnosed in 2011 compared to 2010. With 18 cases in 2012, the congenital syphilis rate in Bexar County was 75.3 per 100,000 live births, a rate far surpassing any recent year. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011).

The United States Preventive Services Task Force (USPSTF) recommends screening for syphilis and HIV in high risk adults and adolescents.  

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[http://www.uspreventiveservicestaskforce.org/3rduspstffyphilis/syphilis.htm](http://www.uspreventiveservicestaskforce.org/3rduspstffyphilis/syphilis.htm)  
[http://www.uspreventiveservicestaskforce.org/uspsf/uspsahiv.htm](http://www.uspreventiveservicestaskforce.org/uspsf/uspsahiv.htm)
recommended guidelines from the CDC for providing expanded STD clinical services and targeted syphilis screening.\textsuperscript{85} Metro Health will also follow nationally recommended guidelines from the CDC for HIV screening and linkage to care.\textsuperscript{86} The White House’s National HIV/AIDS Strategy, strongly encourages intensification of HIV prevention activities in communities most affected by HIV.\textsuperscript{87} Due to Bexar County’s high prevalence of syphilis and increased rates of congenital syphilis, Metro Health will follow CDC’s STD Treatment Guidelines that recommend providers to add third trimester syphilis testing for all pregnant women in high prevalence areas for syphilis.\textsuperscript{88}

According to a recent analysis by the Centers for Disease Control and Prevention, rates of HIV infection were associated with areas with low income residents, those with lower socioeconomic status. Within Bexar County, zip codes with the highest counts of new HIV infections were also areas with generally low income/higher poverty residents. The outcomes in this project will focus on targeted HIV and syphilis screening in these areas where hard to reach individuals may reside. The activities of this project will help Metro Health address these challenges and the health of low-income populations including Medicaid eligible populations.

**Relationship to other Projects:**

The Metro Health comprehensive strategy to expand syphilis and HIV prevention screening and treatment among high risk populations supports Metro Health’s pass 1 proposed project for teen pregnancy, STD, and HIV prevention. The syphilis and HIV prevention, screening and treatment program will build knowledge and skills through risk reduction counseling among adolescents to decrease teen pregnancies. Clients in need of access to affordable reproductive healthcare services will be provided referrals. Staff in the syphilis and HIV prevention project will be available to provide or assist with STD/HIV education to the teen mothers and their partners participating in the evidence-based Healthy Outcomes through Perinatal Education and Support (HOPES) project to reduce repeat teen pregnancies.

**Relationship to Other Performing Providers’ Projects in the RHP:**

Aside from the teen pregnancy prevention project there are no other RHP 6 projects that appear to have a direct linkage to this proposed project, however HIV/STD project staff will be available to support any related STD prevention efforts should they arise among the primary care, specialty or mental health services projects proposed. Other regional performing providers may be particular partners for high risk screening activities and provider education to support third trimester syphilis testing and will be engaged throughout the project period.


Plan for Learning Collaborative:

Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 3, 6, 9 and 12 beginning in DY2. Additionally Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.

Project Valuation:

The project selected addresses a need to screen for HIV and syphilis within high risk populations in Bexar County. Based on recommendations from the United States Preventive Services Task Force (USPSTF) screening for syphilis is important for detecting new syphilis cases and increased opportunities to treat these individuals. If left untreated, even during pregnancy, the syphilis infection can lead to a multitude of costly complications for the individual and especially the newborn baby.

One in three Texans with HIV received a late diagnosis of their infection. With earlier diagnosis of HIV infection, therapy can be initiated before severe immunologic compromise occurs. Screening can be cost-effective even before including the important public health benefit from reduced transmission to sex partners. Linking patients who have received a diagnosis of HIV infection to prevention and care is essential. HIV screening without such linkage confers little or no benefit to the patient. Although moving patients into care incurs substantial costs, it also triggers sufficient survival benefits that justify the additional costs. Even if only a limited fraction of patients who receive HIV-positive results are linked to care, the survival benefits per dollar spent on screening represent good comparative value. Mean cumulative treatment expenditures ranged from $27,275 to $61,615 higher for late than early presenters. After seven to eight years in care, the difference was still substantial. Therefore, screening these individuals for HIV and syphilis is a valued strategy.

Based on locally obtained data for 2011, the average cost to deliver and treat an infant born with congenital syphilis was $54,677. The average length of hospital stay in these cases was 14 days (ranging from 1 to 45 days). These costs do include the costs to the mother or of ongoing care needed for infants that may be born with significant physical and/or developmental disabilities. Using the 2011 average cost to an infant, the projected cost of care to the 18 infants with a presumptive diagnosis of congenital syphilis in 2012 would be $984,186. Bexar county hospitals

91 Branson, B.M., et.al. (2006) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 55 (RR14);1-17. available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5514a1.htm?iframe=true&width=80%&height=80%
92 Branson, B.M., et.al. (2006) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 55 (RR14);1-17. available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5514a1.htm?iframe=true&width=80%&height=80%
could see these costs reduced when a pregnant woman with syphilis is also tested for syphilis in the third trimester, in accordance with CDC STD treatment guidelines\textsuperscript{93} to prevent congenital syphilis in the infant.

Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following factors in assigning a value to this health promotion project: achievement of waiver goals, community need, project scope and the level of project investment.

- This project was ranked high on achievement of waiver goals given the high potential for reduction of healthcare costs through primary prevention outreach activities, and early identification of infections leading to treatment and avoidance of complications such as congenital syphilis cases.
- This project was ranked moderate in regards to addressing a community need. Rates of HIV and STDs are increasing and are higher than state levels. Sexual health has been identified as one of the five priority areas through the Bexar County Community Health Improvement Plan.
- This project was ranked moderate on project scope in that services will be significantly expanded but will be targeted to those geographic and demographic segments of the population that have been shown to be at higher risk for infection based on local data sources.
- This project was ranked moderate in regards to program investment as project will focus on the relatively low-cost intervention of field-based education and testing and include coordination of existing HIV and STD prevention resources. Additional clinic-based treatment and case management activities will be more resource intensive.

<table>
<thead>
<tr>
<th>091308902.2.4 PASS 2</th>
<th>2.7.6</th>
<th>NA</th>
<th>2.7.6 Implement other evidence-based disease prevention programs in an innovative manner: HIV and Syphilis Reduction in Bexar County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider: San Antonio-Metropolitan Health District</td>
<td>TPI - 082426001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td></td>
<td></td>
<td>Other USPSTF-endorsed screening outcome measures Other USPSTF-endorsed screening outcome measures Other Outcome Improvement Target – Third Trimester Syphilis Screening</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Establish protocols for new HIV and syphilis prevention activities</td>
<td><strong>Milestone 4</strong> [I-X]: Implement field testing for HIV an syphilis</td>
<td><strong>Milestone 7</strong> [I-X]: Implement field testing for HIV an syphilis</td>
<td><strong>Milestone 10</strong> [I-X]: Implement field testing for HIV an syphilis</td>
</tr>
<tr>
<td>Metric 1 [P-X-1]: Develop a communication protocol between surveillance, field and clinic supervisory staff to include weekly meetings and monthly reports. Goal: Surveillance, field and clinic staff participate in developing coordinated plan and protocols. Data Source: Communication protocol that coordinates targeted screening.</td>
<td>Metric 1 [I-X-1]: Number of high risk adults and adolescents (13 years of age or greater) screened for HIV infection and/or syphilis in the field Baseline: 0 Goal: 800 Data Source: Field screening log</td>
<td>Metric 1 [I-X-1]: Number of high risk adults and adolescents (13 years of age or greater) screened for HIV infection and/or syphilis in the field Baseline: 0 Goal: 800 Data Source: Field screening log</td>
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</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X-2]: Develop a case management protocol to include coordination between surveillance and clinic teams and guidelines for case management staff.</td>
<td><strong>Milestone 5</strong> [I-X]: Implement congenital syphilis case management activities</td>
<td><strong>Milestone 8</strong> [I-X]: Implement congenital syphilis case management activities</td>
<td><strong>Milestone 11</strong> [I-X]: Implement congenital syphilis case management activities</td>
</tr>
<tr>
<td></td>
<td>Milestone 4 Estimated Incentive Payment: $688,714.66</td>
<td>Milestone 7 Estimated Incentive Payment: $698,301.66</td>
<td>Milestone 10 Estimated Incentive Payment: $713,507.66</td>
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</table>

1055 ★ RHP 6 Plan ★ March 8, 2013 San Antonio Metropolitan Health District
| Goal: Surveillance and clinic staff participate in developing coordinated plan and protocols. Data Source: Case management protocol. | Milestone 1 Estimated Incentive Payment: $659,172.66 | Metric 1  
[I-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Milestone 5 Estimated Incentive Payment: $688,714.66 | Metric 1  
[I-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Milestone 8 Estimated Incentive Payment: $698,301.66 | Metric 1  
[I-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Milestone 11 Estimated Incentive Payment: $713,507.66 | Metric 1  
[I-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Milestone 12 Estimated Incentive Payment: $718,507.66 |
|---|---|---|---|---|---|---|
| Milestone 2  
P-X]: Develop outreach plan for providing education and screening to high risk populations | Milestone 6  
[P-X]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Baseline/Goal: Establish an outreach plan for providing education and screening to high risk populations utilizing established community partnerships  
Data Source: Outreach plans and MOUs with community partners | Metric 1  
P-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Metric 1  
P-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Metric 1  
P-X-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars  
Metric 1  
P-X-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars  
Metric 1  
P-X-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars | Metric 1  
P-X-1]: Number of high risk pregnant women provided clinical case management services  
Baseline: 0  
Goal: 120  
Data Source: Case management files  
Milestone 9  
P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Baseline/Goal: Establish a recruitment and education plan targeting high risk populations  
Data Source: Case management files  
Metric 1  
P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars  
Metric 1  
P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars  
Metric 1  
P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.  
Baseline/Goal: Participate in collaborative meetings/calls.  
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars |
Baseline/Goal: Establish an outreach plan for providing education to health care providers to increase third trimester congenital syphilis screening
Data Source: Outreach plans

Milestone 2 Estimated Incentive Payment: $659,172.66

**Milestone 3**
[P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1**
[P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.
Baseline/Goal: Participate in collaborative meetings/calls.
Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes

| Metric 2 | [P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. | webinars including agendas for phone calls, slides from webinars, and/or meeting notes | Webinars including agendas for phone calls, slides from webinars, and/or meeting notes | Metric 2 | [P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. | webinars including agendas for phone calls, slides from webinars, and/or meeting notes | Webinars including agendas for phone calls, slides from webinars, and/or meeting notes | Metric 2 | [P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. | webinars including agendas for phone calls, slides from webinars, and/or meeting notes | Webinars including agendas for phone calls, slides from webinars, and/or meeting notes |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Milestone 6 Estimated Incentive Payment:** | $688,714.66 | | | | **Milestone 9 Estimated Incentive Payment:** | $698,301.66 | | | | **Milestone 12 Estimated Incentive Payment:** | $713,507.66 | | | |
bi-weekly interaction. Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 3 Estimated Incentive Payment: $659,172.66

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $1,977,518</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,066,144</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,094,905</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,140,523</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,279,090**
Identifying Project and Provider Information:

Title: 2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents – Breastfeeding Promotion for Childhood Obesity Prevention
Unique RHP ID#: 091308902.2.5 - PASS 2
Performing Provider: San Antonio Metropolitan Health District
Performing Provider TPI: 082426001

Project Summary:

Provider Description: The San Antonio Metropolitan Health District (Metro Health) is the public health agency charged by State law, City code, and County resolution with the responsibility for providing public health programs in San Antonio and unincorporated areas of Bexar County. Services include health code enforcement, food inspections, immunizations, clinical services, environmental monitoring, disease control, health education, dental health, and emergency preparedness. As a public health department Metro Health provides services to all residents, but has a particular focus on underserved populations and those experiencing health disparities which often include a higher representation of Medicaid funded individuals. Metro Health is one of four local agencies that provide WIC services. The Metro Health WIC program serves over 45,000 women per month.

Intervention(s): This project will implement the Baby Café Model in San Antonio to increase breastfeeding rates and thus reduce childhood obesity rates. The City of San Antonio’s Women, Infants and Children Special Supplemental Nutrition Program (WIC) recognizes the need to motivate and empower women to continue breastfeeding for as long as possible. Thus, WIC would like to propose to establish a “Baby Café” breastfeeding drop-in center to expand services and attract mothers of all ages and from all sectors of the community. This will be done by providing breastfeeding help and support, from both skilled health professionals, para-professionals, and other mothers, in a friendly, non-clinical, café style environment. The approach is to deliver breastfeeding help at “drop-in centers” to mothers from areas of disadvantage and health inequality. The model has been replicated with great success, in large part because of the casual, relaxed atmosphere offered together with a high level of professionalism underpinned by evidence-based information. This environment would enhance the “Loving Support” Model currently used by the WIC program in promoting breastfeeding. Thus the primary goals of this intervention would be: (1) to promote the physical and psychological health of mothers and children through education and training regarding breastfeeding (2) to advance the general public’s knowledge of the health benefits, immediate and long term, of breastfeeding. Additionally satellite Baby Café sites will be established at five WIC clinic sites throughout the City. This project seeks to foster extensive cooperation between the Baby cafe (Popping Dr., Rittiman, Buena Vista, Pecan Valley, Centromed-Military Dr.). Additionally, all four WIC Agencies in San Antonio have agreed to refer clients to the Baby Café for breastfeeding support services.

Women are welcome to receive ongoing support services with as many visits to Baby Café as they wish and are encouraged to participate regularly over an extended period to support breastfeeding duration. Specific activities occurring within the Baby Café visit include:

1. Welcoming a mother to the Baby Café, orienting her to the facility and services, and assessing her needs.
2. If mother is not having breastfeeding problems she will be matched with another mother of similar locality and age to provide peer support on: managing daily life and meeting...
the baby’s changing needs, breastfeeding outside the home, and night time needs and options.

3. If a mother is having breastfeeding problems then she will be assessed by a lactation consultant who will determine the best course of action to resolve the issues the mother is having. The mother will then either meet with a peer counselor or a lactation consultant to resolve breastfeeding problems. At the same time she will also be invited to participate in group discussion sessions with other breastfeeding mothers, as well as given access to resources (handouts, books, pamphlets, videos) at the Baby Café. For mothers with extreme breastfeeding needs/issues a care plan will be developed and follow-up appointments with the lactation consultants will be made as need.

4. Outside referrals will be made to participating mothers who need additional help outside of the Baby Café’s scope of service.

In addition to these individual client services Baby Café staff will conduct community outreach to key partners including hospitals, WIC sites and the local breastfeeding coalition to expand the referral network and promote additional services and resources aimed at increasing breastfeeding rates.

Need for the project: San Antonio has high childhood obesity rates and low breastfeeding rates. Higher breastfeeding initiation and duration rates have been shown to reduce the incidence of childhood obesity and the Baby Café will help improve breastfeeding rates. It is well documented and supported by research that breastfeeding and breast milk are the optimum methods in providing infants the best start in life. Studies suggest that breastfeeding is associated with children and teenagers having less of a chance of being overweight. There are several factors in which breastfeeding reduces the risk of overweight among which include: that breastfed infants are better able to control their intake and better self-regulate and that breastfed infants have higher levels of leptin (an appetite inhibiting hormone) thus lower ratios of body fat. According to CDC the longer the duration of breastfeeding, the lower the odds of a child being overweight. (Harder et al.) “For each month of breastfeeding up to age of 9 months the odds of overweight decreases by 4%. This decline results in more than a 30% decrease in the odds of overweight for a child breastfed for 9 month when compared with a child who was never breastfed.” (Harder et al.)

Target population: The target population will be pregnant and postpartum women throughout San Antonio. Community wide data indicates 15.4% of the total population is Medicaid eligible. A central and accessible location for the Baby Café will be identified and secured during DY2. Additionally to ensure that the Medicaid/indigent population has the opportunity to receive services provided by the Baby Café, satellite Baby Café sites will be established at five WIC clinic sites throughout the City (Popping Dr., Rittiman, Buena Vista, Pecan Valley, Centromed-Military Dr.). Additionally, all four WIC Agencies in San Antonio have agreed to refer clients to the Baby Café for breastfeeding support services.

Category 1 or 2 expected patient benefits: The project seeks to provide services at the Baby Café to at least 500-700 per year in DY3, DY4 and DY5 for a total of at least 1800 women over the term of the waiver.

Category 3 outcomes: OD-8 Perinatal Outcomes
  o IT-8.9 Other Perinatal Outcome – postpartum women who initiate breastfeeding
  o IT-8.9 Other Perinatal Outcome – postpartum women who breastfeed exclusively
**Project Description:**

**Project Overview**

It is well documented and supported by research that breastfeeding and breast milk are the optimum methods in providing infants the best start in life. Studies suggest that breastfeeding is associated with children and teenagers having less of a chance of being overweight. There are several factors in which breastfeeding reduces the risk of overweight among which include: that breastfed infants are better able to control their intake and better self-regulate and that breastfed infants have higher levels of leptin (an appetite inhibiting hormone) thus lower ratios of body fat. According to CDC the longer the duration of breastfeeding, the lower the odds of a child being overweight. (Harder et al.) “For each month of breastfeeding up to age of 9 months the odds of overweight decreases by 4%. This decline results in more than a 30% decrease in the odds of overweight for a child breastfed for 9 month when compared with a child who was never breastfed.” (Harder et al.)

In the United States, according to the CDC’s 2012 “Breastfeeding Report Card”, 81% of women who deliver attempt to breastfeed; however, exclusively breastfeeding at the end of 6 months decreases to only 25.5%. In response to the sharp drop in mothers who initiate breastfeeding versus the number of mothers who continue to breastfeed 6 months postpartum, Healthy People 2020 have set out several benchmark goals to increase breastfeeding duration at 3 months, 6 months, and 1 year postpartum. Hence the need to improve the duration of breastfeeding among mothers who initiate breastfeeding is apparent and interventions to assist in meeting increased duration goals put into effect. It is documented in the CDC’s report that Mother-to-Mother support is essential to the success and satisfaction a mother experiences while breastfeeding. Those who receive support have longer duration rates and thus have infants whose risk for obesity is decreased. Therefore, evidence based interventions that facilitate mother to mother support as well as professional support would be ideal in addressing and meeting breastfeeding duration goals.

**Goals and Relationship to Regional Goals**

The City of San Antonio’s Women, Infants and Children Special Supplemental Nutrition Program (WIC) recognizes the need to motivate and empower women to continue breastfeeding for as long as possible. Thus, the Metro Health WIC program would like to propose to establish a “Baby Café” breastfeeding drop-in center to expand services and attract mothers of all ages and from all sectors of the community. Services will be available to all women regardless of enrollment in WIC. This will be done by providing breastfeeding help and support, from both skilled health professionals, para-professionals, and other mothers, in a friendly, non-clinical, café style environment. The approach is to deliver breastfeeding help at “drop-in centers” to mothers from areas of disadvantage and health inequality. The model has been replicated with great success, in large part because of the casual, relaxed atmosphere offered together with a high level of professionalism underpinned by evidence-based information. This environment would enhance the “Loving Support” Model currently used by the WIC program in promoting breastfeeding. Thus the primary goals of this intervention would be: (1) to promote the physical and psychological health of mothers and children through education and training regarding breastfeeding (2) to advance the general public’s knowledge of the health benefits, immediate and long term, of breastfeeding. Overall the Baby Café will seek to increase breastfeeding initiation, duration with a goal of up to 12 months of breastfeeding, and exclusivity to support
childhood obesity prevention efforts.

This project meets the following regional goals:
This project directly addresses the RHP 6 need to improve services that affect maternal and child health within the region (CN.5).

Challenges/Plans to Address Challenges:

1. **Issue**: Despite benefits for both mothers and infants, rates of breastfeeding in the United States remain suboptimal, as per a 2004 CDC Survey showing only 74% of infants born in 2004 initiated breastfeeding, 42% continued breastfeeding at 6 months, and 21% breastfeeding at 12 months of age.
   
   **Response**: In the CDC’s 2012 “Breastfeeding Report Card”, 81% of women who deliver attempt to breastfeed; however, exclusively breastfeeding at the end of 6 months decreases to only 25.5%. In 2011 data provided by the Huddersfield Baby Café (Huddersfield, West Yorkshire, UK), the services provided by the Baby Café helped improve breastfeeding duration rates at 6 months from the United Kingdom’s average of 25% at 6 months to over 50% at 6 months. By providing essential support and help during the initial stages of breastfeeding and subsequently through individual counseling and group support the Baby Café was able to impact breastfeeding duration rates in Huddersfield. With the same model and intervention the San Antonio Baby Café will positively impact breastfeeding outcomes and improve breastfeeding rates, as seen at the Huddersfield Baby Café.

2. **Issue**: Insufficient education by Health Providers on the benefits of breastfeeding to include decrease in obesity among children, less ear infections etc.
   
   **Response**: The Baby Café will help fill this gap by proving women information on short and long term benefits of breastfeeding during visits to the Baby Café. Additionally, during Baby Café group sessions, individual counseling and guest speakers this information will be reiterated by Licensed Professional Staff and Peer Counselors.

3. **Issue**: Lack of discussion on how it benefits mothers such as less incidence of Breast cancer, uterus shrinkage, less bleeding, etc.
   
   **Response**: Providing information and resources via literature, journals, books, and through on-line resources is one of the benefits that the Baby Café will provide to breastfeeding mothers in the community. Because of the relaxed/café type environment a Baby Café is the perfect setting for women to come together to learn one on one or through the resources that are available.

4. **Issue**: Breastfeeding initiation rates continue to improve, however many women still chose to Breastfeed and supplement with formula thus resulting in lower breastfeeding duration rates.
   
   **Response**: The CDCs Guide to Breastfeeding Interventions include peer support, educating mothers, and professional support among the effective evidence based interventions to increase initiation, exclusivity and duration of breastfeeding. All these interventions are a major part of what the Baby Café offers, and women who utilize the Baby Café will receive peer encouragement, and support and education by professionals that understand the needs of a breastfeeding mom.

5. **Issue**: The availability of formula is an enabler to steer away from breastfeeding.
   
   **Response**: By partnering with local WIC agencies (a main provider of formula in the community) and setting up satellite Baby Café sites within WIC clinics, the Baby Café should be able to educate and help mothers who are considering discontinuing breast feeding.
milk in lieu of formula. Many mothers turn to formula as a feeding alternative due to unresolved breastfeeding problems which can impede a mother’s ability to naturally breastfeed. Hence, the Baby Café’s staff’s ability to provide resources, to educate, and to guide and support women during their prenatal visits, transition after delivery and thereafter will help to keep mother’s breastfeeding instead of formula feeding.

6. **Issue:** Hospital protocols need to ensure mothers receive the quality of care needed to have a successful breastfeeding experience prior to discharge.

   **Response:** By partnering with the San Antonio Breastfeeding Coalition, the Baby Café will have a direct link to communicate with lactation consultants and nurses who run maternity wards at hospitals within the City. This interaction will enable both entities to provide feedback and support to improve protocols and address the needs of breastfeeding mothers.

7. **Issue:** Support system need to be in place for all women 24/7 by the hospital where they deliver. Quite often upon discharge babies go through a transition period and have difficulties that were not encountered during their hospital stay.

   **Response:** The Baby Café is staffed with Professionals that understand hospital protocol and continuation of care of a mom and her newborn. By reaching out to her local Baby Café mothers will have access to a help line (via phone) and will be able to visit during evening hours and Saturdays. This accessibility will support her during those hours that she is not able to access services that operate on traditional work schedules.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcome will be to increase breastfeeding rates for the women served by the Baby Café. At least 1800 women per year will receive Baby Café services.

**Starting Point/Baseline:**
The City of San Antonio Metropolitan Health District does not offer drop in breastfeeding services. The current breastfeeding initiation rate for the City of San Antonio Metropolitan Health District WIC program is 70%.

**Rationale:**

Rationale
Obesity is a national public health problem that not only afflicts adults but also the pediatric population. As per the CDC’s 2007 report: “Does Breastfeeding Reduce the Risk of Pediatric Overweight?” it is well documented that breastfeeding is associated with decreased risk of pediatric overweight. Initiation, duration, and exclusivity of breastfeeding all impact the reduced risk of pediatric overweight in that those infants who initiate breastfeeding, are breastfed over a longer period (duration), and/or have been exclusively breastfed all display reduced odds of pediatric overweight. The CDC’s report also provides examples of effective evidence based interventions which include: peer support, educating mothers, professional support, and media and social marketing.

The Baby Café model is set up to provide peer support, to educate mothers through counseling and available educational materials, to provide professional support through lactation consultants, dietitians, nurses, and peer counselors. The Baby Café has been shown to be effective in improving breastfeeding outcomes, and currently the model has been adapted at 137 sites across 6 countries. In 2011, the Huddersfield Baby Café (Huddersfield, West Yorkshire, UK) Annual Report revealed that out of the 250 participants surveyed, 78% indicated that attending the Baby Café helped them continue to breastfeed. Additionally, over 84% of the respondents breastfed their babies for six weeks or longer, 71% breastfed their babies for 3
months or longer, and over 50% continued to breastfeed at 6 months. A 2005 United Kingdom (UK) Infant Feeding Survey showed that at 6 weeks of age only 48% of UK babies were breastfed and that number dropped to 25% at 6 months of age. Hence, the Huddersfield Baby Café was able to improve breastfeeding duration rates at 6 weeks and 6 months of age above the UK’s national averages. Another report from the UK’s Infant Mortality National Support Team found that the Calderdale Baby Café (Calderdale, West Yorkshire, United Kingdom) was able to increase breastfeeding initiation rates by 10 percentage points and breastfeeding duration rates by six percentage points between 2002 and 2009. In the US, Baby Café USA reported that in 2011 the Baby Cafés in Massachusetts (one church based and one WIC based) were able to impact breastfeeding exclusivity rates among participating mothers. The Massachusetts Baby Cafes had breastfeeding exclusivity rates of 91% at birth – 3 weeks, 94% at 3 months, and 97% at 6 months versus the Statewide rates of 76.9 % at birth, 42.8 % at 3 months, and 14.1 % at 6 months. In San Antonio, the University Health System briefly hosted a Baby Café at a Metro Health WIC Clinic from November 2010 to August 2011, and during that time was able to increase breastfeeding initiation rates at that site from 81% to 90% (services were discontinued when a state grant ended). The Baby Café model has a strong evidence base for positively impact breastfeeding outcomes and more specifically has been shown to increase initiation, duration, and exclusivity of breastfeeding. Given the consistency with CDC breastfeeding support guidelines, history in a variety of communities nationally and internationally, and due the local support for partnership with local hospitals and WIC sites the San Antonio Metropolitan Health District would like to implement it in the San Antonio Community.

Unique community need identification number the project addresses:
This project directly addresses the RHP 6 need to improve services that affect maternal and child health within the region (CN.5).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
San Antonio Metropolitan Health District’s WIC Program previously hosted a Baby Café sponsored by University Health System’s grant from the Texas Department of Health Services. The grant ran for six months and significantly impacted breastfeeding rates at the clinic in which it was housed. Breastfeeding initiation rates went from 81% to 90%, and through the intervention this clinic site continues to report the highest breastfeeding initiation rate for all Metro Health WIC sites. Unfortunately, due to budget cuts at the State level, the money for the grant ran out and so the program ended in December 2011. The Department of State Health Services WIC Program endorses the Baby Café as an effective model and has encouraged WIC sites in Dallas, Houston, Austin, El Paso, and the Rio Grande Valley to open lactation sites/Baby Cafes.

Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>OD-8 Perinatal Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-8.9 Other Perinatal Outcome – postpartum women who initiate breastfeeding</td>
</tr>
<tr>
<td>IT-8.9 Other Perinatal Outcome – postpartum women who breastfeed exclusively</td>
</tr>
<tr>
<td>IT-8.9 Other Perinatal Outcome – duration of breastfeeding among postpartum women</td>
</tr>
</tbody>
</table>

Reasons/rationale for selecting the outcome measures:
Metro Health’s WIC Program has seen the positive effects that the intervention provided by the
Baby Café can have on a mother’s choice to initiate breastfeeding, and with an ongoing program that is open to all expectant mothers in the San Antonio Community the possibility of reproducing these outcomes on a larger scale exists. Hence, Metro Health has developed three Category 3 Outcomes: (1) increase breastfeeding initiation for those mothers serviced at the Baby Café (2) increase breastfeeding duration for those mothers serviced at the Baby Café (3) increase breastfeeding exclusivity for those mothers serviced at the baby café.

As per the CDC’s 2007 report: “Does Breastfeeding Reduce the Risk of Pediatric Overweight?” breastfeeding initiation, duration, and exclusivity are key in reducing pediatric overweight. The CDC’s meta-analysis of nine studies showed that infants who initiated breastfeeding resulted in a significant overall reduced risk of overweight. Furthermore, the report states that the protection against overweight from being initially breastfed versus being given formula may persist into teenage years and adulthood. Additionally, the meta-analysis goes on to state that breastfeeding is inversely related to pediatric overweight, and that for each month an infant is breastfed (up to nine months) the odds of overweight decreased by 4%. This results in up to a 30% decrease in odds of pediatric overweight if breastfed up to nine months compared to a child who was never breastfed. Moreover, the report finds that in a study conducted by Harder et al., that exclusive breastfeeding showed a stronger protective effect in decreasing the odds of overweight by 6% for each month of exclusive breastfeeding.

The mentioned outcomes are a priority for the RHP as supported by local obesity and breastfeeding data. According to 2007 Metro Health WIC obesity data, of the children serviced by the program 31% were overweight or obese, compared to the 2007 State Average of 21.3%. Additionally, breastfeeding initiation rates for Metro Health WIC average 70% where as the State average is 82%. As per the Children’s Hospital Association of Texas, in 2005 national Medicaid spending to treat childhood obesity hospitalization was $118.1 million, a 120% increase since 2001. Hence, at this same rate of increase by the year 2009 Medicaid would have spent $260 million on childhood obesity hospitalization. Because of the high cost spent by Medicaid to treat childhood obesity the need for more interventions to address this problem is apparent. Metro Health’s statistics confirm a high obesity rate for children ages 2-5 and also confirm a lower breastfeeding initiation rate. Thus, the outcomes proposed by this intervention will help in addressing obesity in both Medicaid and WIC populations (lower income) but will also address the problem within Bexar County as a whole.

**Relationship to other Projects:**
The Metro Health Baby Café intervention will support the Metro Health project 091308902.2.1 on teen pregnancy prevention by recruiting teen mothers served in the case management arm of the project to participate in Baby Café drop in sessions, education, and counseling.
<table>
<thead>
<tr>
<th>Relationship to Other Performing Providers’ Projects in the RHP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan for Learning Collaborative:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro Health will foster Continuous Quality Improvement (CQI) through active participation in the RHP 6 learning collaborative working groups to support and enhance project quality improvement, evaluation and achievement of outcomes. CQI elements are specifically included through milestones 3, 6, 9 and 12 beginning in DY2. Additionally Metro Health will seek out project specific opportunities to collaborate with regional maternal and child health as well as other local health department performing providers in other Texas regions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Valuation:</th>
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</thead>
<tbody>
<tr>
<td>Breastfeeding is not only the most nutritious way of feeding an infant but also cost effective. Breastfeeding can save parents anywhere between $700 to $3000 dollars during the first year of life (on money not spent on formula). A study by Montgomery et al. also showed that breastfed infants had a cost saving of $112 in Medicaid expenditures during the first six month of life versus formula fed infants. A 2010 UNICEF report assessing the economic benefits of breastfeeding estimated that around $13 billion would be saved if breastfeeding were increased from current levels (13.3%) to 90 percent of women breastfeeding exclusively for six months.</td>
</tr>
<tr>
<td>Utilizing the methodology provided by the RHP 6 anchor, Metro Health assessed the following factors in assigning a value to this health promotion project: achievement of waiver goals, community need, project scope and the level of project investment.</td>
</tr>
<tr>
<td>• This project was ranked high on achievement of waiver goals given the strong research and high potential for reduction of healthcare costs associated with childhood obesity for Medicaid and other underserved populations in Bexar County. This project has the potential to significantly improve breastfeeding rates which have been shown in the research to reduce the risk of childhood obesity, among other health benefits.</td>
</tr>
<tr>
<td>• This project was ranked low in regards to addressing a community need. Childhood obesity has been demonstrated as a particular concern, and local breastfeeding rates are below the state average, however breastfeeding as a strategy to address obesity rates has not been well recognized yet by local providers and residents.</td>
</tr>
<tr>
<td>• This project was ranked low on project scope in that services will be available to all postpartum women from a variety of referral sources however anticipated numbers of clients served is relatively small compared to other proposed projects.</td>
</tr>
<tr>
<td>• This project was ranked low in regards to program investment given the relatively low cost of the intervention for participants.</td>
</tr>
<tr>
<td>Performing Provider: San Antonio-Metropolitan Health District</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Related Category 3</strong>&lt;br&gt;Outcome Measure(s):&lt;br&gt;091308902.3.15 IT-8.9&lt;br&gt;091308902.3.16 IT-8.9&lt;br&gt;091308902.3.17 IT-8.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt;[P-X]: Establish Baby Café to provide breastfeeding support and services to increase breastfeeding rates</td>
<td><strong>Milestone 4</strong>&lt;br&gt;[P-X]: Share information and resources with potential Baby Café participants and referral agencies</td>
<td><strong>Milestone 7</strong>&lt;br&gt;[P-X]: Share information and resources with potential Baby Café participants and referral agencies</td>
<td><strong>Milestone 10</strong>&lt;br&gt;[P-X]: Share information and resources with potential Baby Café participants and referral agencies</td>
</tr>
<tr>
<td>Metric 1&lt;br&gt;[P-X-1]: Establish Baby Café&lt;br&gt;Baseline/Goal: Obtain Baby Café licensure&lt;br&gt;Data Source: Application and Baby Café License</td>
<td>Metric 1&lt;br&gt;[P-X-1]: Implement Outreach and Marketing Plan&lt;br&gt;Goal: Contact 600 potential Baby Café clients&lt;br&gt;Data Source: Outreach documentation and logs</td>
<td>Metric 1&lt;br&gt;[P-X-1]: Implement Outreach and Marketing Plan&lt;br&gt;Goal: Contact 600 potential Baby Café clients&lt;br&gt;Data Source: Outreach documentation and logs</td>
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</tr>
<tr>
<td><strong>Milestone 2</strong>&lt;br&gt;[P-X-1]: Establish Baby Café&lt;br&gt;Baseline/Goal: Establish Baby Café location&lt;br&gt;Data Source: Lease or rental agreement for Baby Café</td>
<td><strong>Milestone 5</strong>&lt;br&gt;[I-5]: Establish clientele receiving services at the Baby Café</td>
<td><strong>Milestone 8</strong>&lt;br&gt;[I-5]: Establish clientele receiving services at the Baby Café</td>
<td><strong>Milestone 11</strong>&lt;br&gt;[I-5]: Establish clientele receiving services at the Baby Café</td>
</tr>
<tr>
<td><strong>Metric 2</strong>&lt;br&gt;[P-X-1]: Establish Baby Café&lt;br&gt;Baseline/Goal: Establish Baby Café location&lt;br&gt;Data Source: Lease or rental agreement for Baby Café</td>
<td><strong>Metric 4</strong>&lt;br&gt;Milestone 4 Estimated Incentive Payment: $393,551.33</td>
<td><strong>Metric 7</strong>&lt;br&gt;Milestone 7 Estimated Incentive Payment: $399,029.66</td>
<td><strong>Metric 10</strong>&lt;br&gt;Milestone 10 Estimated Incentive Payment: $407,718.66</td>
</tr>
<tr>
<td><strong>Metric 5</strong>&lt;br&gt;[I-5]: Establish clientele receiving services at the Baby Café</td>
<td><strong>Metric 1</strong>&lt;br&gt;Milestone 5 Estimated Incentive Payment: $376,670.00</td>
<td><strong>Metric 8</strong>&lt;br&gt;Milestone 8 Estimated Incentive Payment: $407,718.66</td>
<td><strong>Metric 11</strong>&lt;br&gt;Milestone 11 Estimated Incentive Payment: $407,718.66</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong>&lt;br&gt;$376,670.00</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong>&lt;br&gt;$393,551.33</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong>&lt;br&gt;$399,029.66</td>
<td><strong>Milestone 10 Estimated Incentive Payment:</strong>&lt;br&gt;$407,718.66</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $376,670.00</td>
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**Milestone 3**

<table>
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<tr>
<th>[P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</th>
</tr>
</thead>
</table>

**Metric 1**

<table>
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<tr>
<th>[P-5-1]: Number of mothers receiving services at the Baby Café</th>
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<table>
<thead>
<tr>
<th>[I-5-1]: Number of mothers receiving services at the Baby Café</th>
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</table>

**Baseline/Goal:**

<table>
<thead>
<tr>
<th>的目标: 500 mothers receiving Baby Café services</th>
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</table>

Data Source: Baby Café attendance logs

Milestone 5 Estimated Incentive Payment: $393,551.33

**Milestone 6**

<table>
<thead>
<tr>
<th>[P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</th>
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**Metric 1**

<table>
<thead>
<tr>
<th>[P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</th>
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<tr>
<th>[I-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</th>
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</thead>
</table>

**Baseline/Goal:**

<table>
<thead>
<tr>
<th>Baseline: 0</th>
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</table>

Goal: 600 mothers receiving Baby Café services |

Data Source: Baby Café attendance logs

Milestone 8 Estimated Incentive Payment: $399,029.66

**Milestone 9**

<table>
<thead>
<tr>
<th>[P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</th>
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</thead>
</table>

**Baseline/Goal:**

<table>
<thead>
<tr>
<th>Baseline: 0</th>
</tr>
</thead>
</table>

Goal: 700 mothers receiving Baby Café services |

Data Source: Baby Café attendance logs

Milestone 11 Estimated Incentive Payment: $407,718.66

**Milestone 12**

<table>
<thead>
<tr>
<th>[P-5]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</th>
</tr>
</thead>
</table>

**Metric 1**

<table>
<thead>
<tr>
<th>[P-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>[I-5-1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</th>
</tr>
</thead>
</table>

**Baseline/Goal:**

<table>
<thead>
<tr>
<th>Baseline: 0</th>
</tr>
</thead>
</table>

Goal: 700 mothers receiving Baby Café services |

Data Source: Baby Café attendance logs

Milestone 12 Estimated Incentive Payment: $407,718.66
meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes

Metric 2
[P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction.
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 3 Estimated Incentive Payment: $376,670.00

Metric 2
[P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction.
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 6 Estimated Incentive Payment: $393,551.33

Metric 2
[P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction.
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 9 Estimated Incentive Payment: $399,029.66

Metric 2
[P-5-2]: Share challenges and solutions successfully during this bi-weekly interaction.
Baseline/Goal: Share challenges and solutions in collaborative meetings/calls. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.

Milestone 12 Estimated Incentive Payment: $407,718.66

Year 2 Estimated Milestone Bundle Amount: $1,130,010
Year 3 Estimated Milestone Bundle Amount: $1,180,654
Year 4 Estimated Milestone Bundle Amount: $1,197,089
Year 5 Estimated Milestone Bundle Amount: $1,223,156

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,730,909
E. Category 3: Quality Improvements

<table>
<thead>
<tr>
<th>Identifying Outcome Measure and Provider Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td>RHP Outcome Identification Number: 159156201.3.1 – PASS 1</td>
</tr>
<tr>
<td>Provider Name: VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
</tr>
<tr>
<td>TPI: 159156201</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Measure Description:</th>
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</thead>
<tbody>
<tr>
<td>IT-1.10 Diabetes Care: HbA1c poor control (&gt;9%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestones:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DY2</td>
</tr>
<tr>
<td>Process Milestone 1- P-2 Establish Baseline rates</td>
</tr>
<tr>
<td>Assess Athena database for all MSO Primary Care patients with Type 1 or Type 2 diabetes</td>
</tr>
<tr>
<td>Process Milestone 2 P-2 Establish Baseline rates</td>
</tr>
<tr>
<td>Determine baseline A1c value for each patient identified in Milestone 1 (using times period 1-1-12 through 9-30-12)</td>
</tr>
<tr>
<td>• DY3</td>
</tr>
<tr>
<td>Process Milestone 3- P-2 Establish Baseline rates</td>
</tr>
<tr>
<td>Calculate % of MSO patients with A1c level &gt; 9% within last 12 months for all identified patients in database</td>
</tr>
<tr>
<td>Process Milestone 4 P-7 Other Activities</td>
</tr>
<tr>
<td>Document all reminders/callbacks to patients for A1c testing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Targets for each year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DY4-IT-1.10 Increase % of patients with A1c &lt;9% over baseline by 3%</td>
</tr>
<tr>
<td>• DY5-IT-1.10 Increase % of patients with A1c &lt;9% over baseline by 5%</td>
</tr>
</tbody>
</table>

In the Agency for Healthcare Research and Quality’s 2011 report, Texas ranks last in the nation on health care quality. In the same report, Texas scored particularly weak on diabetes care. Diabetes is in the top list of causes of death in RHP6. Diabetes care management is in the targets listed in RHP 6 Community Needs plan.

Process milestones:

Process milestones 1-4 were chosen to take our current MSO patient population and calculate a
baseline rate of % of patients with diabetes that have an A1C <9%. By implementing a call back system for follow-up testing and adjusting diabetes care as indicated, we can improve this measure for our MSO patient base. By adding incremental primary care sites and providers, we will care for more of our RHP patient population and yet have a mechanism in place to monitor and improve their diabetes control through focused follow-up care by our primary care physicians.

**Improvement target:**

Improvement target is the measure itself and we want to grow the % < 9% which indicates the patient’s diabetes is in control.

This is a relevant outcome measure for project 1.1 Expand Primary Care Capacity.

**Outcome Measure Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Since diabetes disease and lack of quality management is identified as a high need in RHP 6RGs, focus on successful management resulting in reduced # of patients with A1c > 9 improves the patient health status, reduces costs and avoids admissions, thus creating greater access for the RHP 6 underserved patient population.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> (P-2): Establish Baseline rates</td>
<td><strong>Process Milestone 2</strong> (P-2): Establish Baseline rates</td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>Determine # of MSO patients with Type 1 or Type 2 diabetes</td>
<td>Calculate A1c value for each patient identified in Milestone 1 (using time period 1-1-12 through 9-30-12) – latest A1c on file during that time period will be baseline.</td>
<td>Improvement Target: Calculate % of MSO patients with A1c &lt; 9% with a 3% improvement over baseline as goal</td>
<td>Improvement Target: Calculate % of MSO patients with A1c &lt; 9% with a 5% improvement over baseline as goal</td>
</tr>
<tr>
<td>Data Source: Athena/Crimson</td>
<td>Data Source: Athena/Crimson</td>
<td>Data Source: Athena/Crimson</td>
<td>Data Source: Athena/Crimson</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $81,235</td>
<td>Process Milestone 2 Estimated Incentive Payment: $81,235</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $302,196</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $722,642</td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong> (P-2): Establish Baseline rates</td>
<td><strong>Process Milestone 4</strong> (P-7) Other Activities</td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>Calculate % of patients with A1c &gt; 9.0%</td>
<td>Document all reminders/callbacks to patients for A1c testing.</td>
<td>Improvement Target: Calculate % of MSO patients with A1c &lt; 9% with a 3% improvement over baseline as goal</td>
<td>Improvement Target: Calculate % of MSO patients with A1c &lt; 9% with a 5% improvement over baseline as goal</td>
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</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $162,471</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $188,325</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $302,196</strong></td>
<td><strong>Year 5 Estimated Outcome Amount: $722,642</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,375,634**
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Outcome Identification Number: 159156201.3.2 – PASS 1</td>
</tr>
<tr>
<td>Provider Name: VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
</tr>
<tr>
<td>TPI: 159156201</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

**Outcome Measure Description:**

IT-3.2 Congestive Heart Failure 30 day readmission rate

**Process Milestones:**

- **DY2**
  - Process Milestone 1 P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - Establish CHF Navigator Program
  - Process Milestone 2 P-7 Other Activities
  - Inventory post acute care providers for CHF management programs
- **DY3**
  - Process Milestone 3 P-7 Other Activities
  - Establish formal post acute care provider relationships for CHF Management programs and utilize these providers
  - Process Milestone 4 P-7 Other Activities
  - Implement extensive CHF teaching program for patients and families

**Outcome Improvement Targets for each year:**

- **DY4**
  - IT -3.2 Show improvement through 3% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%
- **DY5**
  - IT- 3.2 Show improvement through 5% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%

**Rationale:**

Patients with acute or chronic CHF consume major healthcare resources with repeat hospital stays. Readmission rates increase as the patient ages and with the number of co-morbidities. Reducing preventable readmissions helps reduce costs and improve quality of care and life for the patient and family. BHS will institute a care coordination process that extends to the CHF patient’s home and into other health-care facilities
Process milestones:

Process milestones 1-4 were chosen because a key aspect of this care delivery system seeks to provide a smooth transition from the hospital setting through partnership with other health care providers to “transition” the patient instead of simply “handing-off” the patient. Education of the patient and family caregivers and ensuring proper follow-up with the primary care physician is critical. Facilitating the appropriate level of care at time of discharge begins upon admission and is a major focus for our Case Management team. BHS will also focus on hospice and palliative care models to assist CHF patient in terminal phase to avoid hospitalizations while maintaining a high quality end-of-life care.

Improvement target:

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 1 Project 1.9 Expand Specialty Care as our cardiologists and other specialists work with the hospitals’ case managers and post acute care providers to manage their chronic CHF patients in an OP setting and prevent hospitalizations.

Outcome Measure Valuation:

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Since CHF is a high volume DRG and is also a high volume diagnosis in other DRGs, focus on successful management resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
<table>
<thead>
<tr>
<th>TPI: 159156201.3.2 PASS 1</th>
<th>3.IT-3.2</th>
<th>Congestive Heart Failure 30 Day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
<td>159156201.1.2</td>
<td>TPI - 159156201</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine Develop job description and hire for CHF Navigator positions</td>
<td><strong>Process Milestone 3</strong> [P-7] Other Activities Establish formal post acute care provider relationships for CHF Management programs and utilize these providers Data Source: Implementation plans evidence of preferred provider arrangements</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-3.2]: CHF 30 day readmission rate Improvement Target: 3% Reduction in CHF 30 day readmission rate from baseline of 12.4% Data Source: BHS STAR patient accounting and Avega systems</td>
</tr>
<tr>
<td>Data Source: Job description &amp; HR records for persons in the role Process Milestone 1 Estimated Incentive Payment: $81,236</td>
<td>Process Milestone 3 Estimated Incentive Payment: $94,162</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $302,196</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-7]: Other Activities Inventory post acute care providers for CHF management programs Data Source: Submission of inventory analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Process Milestone 4</strong> [P-7] Other Activities Implement CHF teaching program for CHF patients and families Data Source: Implementation plans evidence of preferred provider arrangements</td>
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<td></td>
<td>Process Milestone 4 Estimated Incentive Payment: $94,163</td>
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</tr>
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<td>Process Milestone 2 Estimated Incentive Payment: $81,235</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $162,471</td>
<td>Year 3 Estimated Outcome Amount: $188,325</td>
<td>Year 4 Estimated Outcome Amount: $302,196</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,375,634**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate
RHP Outcome Identification Number: 159156201.3.3 – PASS 1
Provider Name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201

Outcome Measure Description:

**Outcome Measure Description:**
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate

Process Milestones:

- **DY2**
  - Process Milestone 1 P-7 Other Activities
    - Prior to discharge secure PCP follow-up appointment scheduled within 3-7 days of discharge
    - Process Milestone 2 P-4 Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities
    - Review 100% of all AMI 30 day readmissions for transitional failure

- **DY3**
  - Process Milestone 3 P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
  - Share data from DY 2 readmission reviews with providers and identify correctional improvements
  - Process Milestone 4 P-7 Other Activities
  - Implement at least 2 new processes following review and data sharing for improved transitional care

Outcome Improvement Targets for each year:

- **DY4**
  - IT-3.5 Show improvement through 3% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

- **DY5**
  - IT-3.5 Show improvement through 5% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

Rationale:

Patients with AMI are more likely to be readmitted within 30 days as complicated by patient age, frailty and frequent comorbid conditions. The rate for readmission in post AMI patients has increased per a 2010 study in “Cardiovascular Quality and Outcomes” but is due to higher non cardiovascular complications. Bexar County has a higher incidence of comorbid conditions such as hypertension, renal failure with dialysis, COPD and diabetes. Additional factors such as pneumonia or impeded swallowing function can also impact readmission rates.
Process milestones:

Process milestones 1-4 were chosen as methods for reducing preventable readmissions which reduces costs and improves quality of care and life for the patient and family. BHS will institute a care coordination process for the AMI patient focusing on a thorough “transition” from the hospital setting through partnership with other health care providers instead of simply “handing-off” the patient. Education of the patient, family, and caregivers and ensuring the timely follow-up with the primary/specialty care physician is critical for successful management in the AMI’s patients post acute status.

Improvement target:

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 1 Project 1.9 Expand Specialty Care as our cardiologists and other specialists work with the hospitals’ case managers and post acute care providers to manage their chronic CHF patients in an OP setting and prevent hospitalizations.

Outcome Measure Valuation:

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Cardiovascular disease (CAD) is prevalent in the RHP 6 patient population. Comorbidities complicating CAD impact serious acute inpatient conditions such as Acute Myocardial Infarctions (AMI) and improved, successful management of AMI resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
<table>
<thead>
<tr>
<th>VHS San Antonio Partners, LLC d/b/a Baptist Health System</th>
<th>TPI - 159156201</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>159156201.1.2</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>9.4%</td>
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<td><strong>Process Milestone 1</strong> [ P-7]: Other Activities</td>
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<tr>
<td>Prior to discharge secure PCP follow-up appointment within 3-7 days of discharge</td>
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</tr>
<tr>
<td>Data Source: Midas, Allscripts</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $81,236</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-4]: Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities</td>
<td></td>
</tr>
<tr>
<td>Review 100% of all AMI 30 day readmissions for transitional failure</td>
<td></td>
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<tr>
<td>Data Source: BHS Quality/Case Management Records</td>
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<td>Process Milestone 2 Estimated Incentive Payment: $81,235</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong> [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
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<tr>
<td>Share data from DY2 readmission reviews with providers, identify correctional improvements</td>
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<tr>
<td>Data Source: Process Improvement Data Records</td>
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</tr>
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<td>Process Milestone 3 Estimated Incentive Payment: $94,117</td>
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<td><strong>Process Milestone 4</strong> [P-7] Other Activities</td>
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<tr>
<td>Implement at least 2 new processes following review and data sharing</td>
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<td><strong>Outcome Improvement Target 1</strong>[IT-3.5]: AMI 30 day readmission rate</td>
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<tr>
<td>Improvement Target: 3% Reduction in AMI 30 day readmission rate from baseline of 9.4 %</td>
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</tr>
<tr>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
<td></td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $302,196</td>
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</tr>
<tr>
<td><strong>Outcome Improvement Target 2</strong>[IT-3.5]: AMI 30 day readmission rate</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: 5% Reduction in CHF 30 day readmission rate from baseline of 9.4 %</td>
<td></td>
</tr>
<tr>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
<td></td>
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<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $722,642</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $162,471</td>
<td>Year 3 Estimated Outcome Amount: $188,325</td>
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</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $1,375,634</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $1,375,634</td>
</tr>
</tbody>
</table>
# Identifying Outcome Measure and Provider Information:

**Title of Outcome Measure (Improvement Target):** IT-3.2 Congestive Heart Failure 30 day readmission rate  
**RHP Outcome Identification Number:** 159156201.3.4 – PASS 1  
**Provider Name:** VHS San Antonio Partners, LLC d/b/a Baptist Health System  
**TPI:** 159156201

## Outcome Measure Description:

**IT-3.2 Congestive Heart Failure 30 day readmission rate**

## Process Milestones:

- **DY2**
  - Process Milestone 1 P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
  - Establish CHF Navigator Program  
  - Process Milestone 2 P-7 Other Activities  
  - Inventory post acute care providers for CHF management programs

- **DY3**
  - Process Milestone 3 P-7 Other Activities  
  - Establish formal post acute care provider relationships for CHF Management programs and utilize these providers  
  - Process Milestone 4 P-7 Other Activities  
  - Implement extensive CHF teaching program for patients and families

## Outcome Improvement Targets for each year:

- **DY4**  
  - IT-3.2 Show improvement through 3% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%

- **DY5**  
  - IT-3.2 Show improvement through 5% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%

## Rationale:

Patients with acute or chronic CHF consume major healthcare resources with repeat hospital stays. Readmission rates increase as the patient ages and with the number of co-morbidities. Reducing preventable readmissions helps reduce costs and improve quality of care and life for the patient and family. BHS will institute a care coordination process that extends to the CHF patient’s home and into other health-care facilities.

## Process milestones:

Process milestones 1-4 were chosen because a key aspect of this care delivery system seeks to provide a smooth transition from the hospital setting through partnership with other health care providers to “transition” the patient instead of simply “handing-off” the patient. Education of the
patient and family caregivers and ensuring proper follow-up with the primary care physician is critical. Facilitating the appropriate level of care at time of discharge begins upon admission and is a major focus for our Case Management team. BHS will also focus on hospice and palliative care models to assist CHF patient in terminal phase to avoid hospitalizations while maintaining a high quality end-of-life care.

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 1 Project 1.10 Enhance PI. Equipping both hospital staff and physicians with a variety of process improvement tools to improve processes and care enables project 2.8 Apply PI to Improve Quality and Efficiency where we have identified wide variation in CHF management (LOS, pharmaceuticals, and diagnostic testing) one of the three identified clinical areas targeted for focused improvement using PI tools through the new Office of Operations Improvement.

**Outcome Measure Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Since CHF is a high volume DRG and is also a high volume diagnosis in other DRGs, focus on successful management resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Process Milestone 4</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine develop job description and hire for CHF Navigator positions</td>
<td>P-7: Other Activities Establish formal post acute care provider relationships for CHF Management programs and utilize these providers</td>
<td>[IT-3.2]: CHF 30 day readmission rate</td>
<td>P-7: Other Activities Implement CHF teaching program for CHF patients and families</td>
<td>[IT-3.2.]: CHF 30 day readmission rate</td>
</tr>
<tr>
<td>Starting Point/Baseline: Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Improvement Target: 3% Reduction in CHF 30 day readmission rate from baseline of 12.4%</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Improvement Target: 5% Reduction in CHF 30 day readmission rate from baseline of 12.4%</td>
</tr>
</tbody>
</table>

**Data Source:** Job description & HR records for persons in the role

**Process Milestone 2**

[P-7]: Other Activities

Inventory post acute care providers for CHF management programs

Process Milestone 2 Estimated Incentive Payment: $81,235

**Process Milestone 3**

[P-7] Other Activities

Establish formal post acute care provider relationships for CHF Management programs and utilize these providers

Data Source: Implementation plans evidence of preferred provider arrangements

Process Milestone 3 Estimated Incentive Payment: $94,162

**Process Milestone 4**

[P-7] Other Activities

Implement CHF teaching program for CHF patients and families

Data Source: Implementation plans evidence of preferred provider arrangements

Process Milestone 4 Estimated Incentive Payment: $94,163

**Outcome Improvement Target 1**

[IT-3.2]: CHF 30 day readmission rate

Improvement Target: 5% Reduction in CHF 30 day readmission rate from baseline of 12.4%

Data Source: BHS STAR patient accounting and Avega systems

Outcome Improvement Target 2 Estimated Incentive Payment: $722,642
<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $162,471</th>
<th>Year 3 Estimated Outcome Amount: $188,325</th>
<th>Year 4 Estimated Outcome Amount: $302,196</th>
<th>Year 5 Estimated Outcome Amount: $722,642</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,375,634</strong></td>
<td></td>
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</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate</th>
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</thead>
<tbody>
<tr>
<td>RHP Outcome Identification Number:</td>
<td>159156201.3.5 – PASS 1</td>
</tr>
<tr>
<td>Provider Name:</td>
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</tr>
<tr>
<td>TPI:</td>
<td>159156201</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

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

**Process Milestones:**

- **DY2**
  - Process Milestone 1 P-7 Other Activities
  - Prior to discharge secure PCP follow-up appointment scheduled within 3-7 days of discharge
  - Process Milestone 2 P-4 Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities
  - Review 100% of all AMI 30 day readmissions for transitional failure

- **DY3**
  - Process Milestone 3 P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
  - Share data from DY 2 readmission reviews with providers and identify correctional improvements
  - Process Milestone 4 P-7 Other Activities
  - Implement at least 2 new processes following review and data sharing for improved transitional care

**Outcome Improvement Targets for each year:**

- **DY4-**
  - IT- 3.5 Show improvement through 3% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

- **DY5-**
  - IT-3.5 Show improvement through 5% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

**Rationale:**

Patients with AMI are more likely to be readmitted within 30 days as complicated by patient age, frailty and frequent comorbid conditions. The rate for readmission in post AMI patients has increased per a 2010 study in “Cardiovascular Quality and Outcomes” but is due to higher non cardiovascular complications. Bexar County has a higher incidence of comorbid conditions such as hypertension, renal failure with dialysis, COPD and diabetes. Additional factors such as pneumonia or impeded swallowing function can also impact readmission rates.
**Process milestones:**

Process milestones 1-4 were chosen as methods for reducing preventable readmissions which reduces costs and improves quality of care and life for the patient and family. BHS will institute a care coordination process for the AMI patient focusing on a thorough “transition” from the hospital setting through partnership with other health care providers instead of simply “handing-off” the patient. Education of the patient, family, and caregivers and ensuring the timely follow-up with the primary/specialty care physician is critical for successful management in the AMI’s patients post acute status.

**Improvement target:**

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 1 Project 1.10 Enhance PI. By equipping both hospital staff and physicians with a variety of process improvement tools, the healthcare team can identify and improve processes in care and for efficiency which are utilized in project 2.8 Apply PI to Improve Quality and Efficiency.

This enables all to provide effective transitional care for post AMI patients and equips the patient/family with resources to successfully manage the AMI patient’s health status outside of the hospital.

**Outcome Measure Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Cardiovascular disease (CAD) is prevalent in the RHP 6 patient population. Comorbidities complicating CAD impact serious acute inpatient conditions such as Acute Myocardial Infarctions (AMI) and improved, successful management of AMI resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
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<tr>
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<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-7]: Other Activities</td>
<td>[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>[IT-3.5]: AMI 30 day readmission rate</td>
<td>[IT-3.5]: AMI 30 day readmission rate</td>
</tr>
<tr>
<td>Prior to discharge secure PCP follow-up appointment within 3-7 days of discharge</td>
<td>Share data from DY2 readmission reviews with providers, identify correctional improvements</td>
<td>Improvement Target: 3% Reduction in AMI 30 day readmission rate from baseline of 9.4%</td>
<td>Improvement Target: 5% Reduction in CHF 30 day readmission rate from baseline of 9.4%</td>
</tr>
<tr>
<td>Data Source: Midas, Allscripts</td>
<td>Data Source: Process Improvement Data Records</td>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $81,236</td>
<td>Process Milestone 3 Estimated Incentive Payment: $94,117</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $302,196</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $722,642</td>
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<tr>
<td>[P-4]: Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities</td>
<td>[P-7]: Other Activities Implement at least 2 new processes following review and data sharing</td>
<td>Process Milestone 4 Estimated</td>
<td>Process Milestone 4 Estimated</td>
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<tr>
<td>Review 100% of all AMI 30 day readmissions for transitional failure</td>
<td>Data Source: Implementation plans</td>
<td>Process Milestone 4 Estimated</td>
<td>Process Milestone 4 Estimated</td>
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<tr>
<td>Data Source: BHS Quality/Case Management Records</td>
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<tr>
<td>Year</td>
<td>Estimated Outcome Amount</td>
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<td>3</td>
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</tr>
<tr>
<td>5</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,375,634**
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate
RHP Outcome Identification Number: 159156201.3.6- PASS 1
Provider Name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201

Outcome Measure Description:
IT-3.2 Congestive Heart Failure 30 day readmission rate

Process Milestones:
- DY2
  Process Milestone 1 P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  Establish CHF Navigator Program
  Process Milestone 2 P-7 Other Activities
  Inventory post acute care providers for CHF management programs
- DY3
  Process Milestone 3 P-7 Other Activities
  Establish formal post acute care provider relationships for CHF Management programs and utilize these providers
  Process Milestone 4 P-7 Other Activities
  Implement extensive CHF teaching program for patients and families

Outcome Improvement Targets for each year:
- DY4
  IT-3.2 Show improvement through 3% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%
  3% was selected since there is less ability to control all cause readmissions while specifically working initiatives to prevent readmissions from same or primary cause
- DY5-
  IT-3.2 Show improvement through 5% reduction in 30 day all cause readmissions for CHF patients over baseline rate for 12 months ending 12-31-11 which =12.4%
  5% was selected since there is less ability to control all cause readmissions while specifically working initiatives to prevent readmissions from same or primary cause.
  However this is a 67% increase in improvement over DY4.
**Rationale:**

Patients with acute or chronic CHF consume major healthcare resources with repeat hospital stays. Readmission rates increase as the patient ages and with the number of co-morbidities. Reducing preventable readmissions helps reduce costs and improve quality of care and life for the patient and family. BHS will institute a care coordination process that extends to the CHF patient’s home and into other health-care facilities.

**Process milestones:**

Process milestones 1-4 were chosen because a key aspect of this care delivery system seeks to provide a smooth transition from the hospital setting through partnership with other health care providers to “transition” the patient instead of simply “handing-off” the patient. Education of the patient and family caregivers and ensuring proper follow-up with the primary care physician is critical. Facilitating the appropriate level of care at time of discharge begins upon admission and is a major focus for our Case Management team. BHS will also focus on hospice and palliative care models to assist CHF patient in terminal phase to avoid hospitalizations while maintaining a high quality end-of-life care.

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 1 Project 1.10 Enhance PI. Equipping both hospital staff and physicians with a variety of process improvement tools to improve processes and care enables project 2.8 Apply PI to Improve Quality and Efficiency where we have identified wide variation in CHF management (LOS, pharmaceuticals, and diagnostic testing) one of the three identified clinical areas targeted for focused improvement using PI tools through the new Office of Operations Improvement.

**Outcome Measure Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Since CHF is a high volume DRG and is also a high volume diagnosis in other DRGs, focus on successful management resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
### Process Milestone 1 [P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine Develop job description and hire for CHF Navigator positions

**Data Source:** Job description & HR records for persons in the role

**Process Milestone 1 Estimated Incentive Payment:** $81,236

### Process Milestone 2 [P-7]: Other Activities

**Inventory post acute care providers for CHF management programs**

**Process Milestone 2 Estimated Incentive Payment:** $81,235

### Process Milestone 3 [P-7]: Other Activities

**Establish formal post acute care provider relationships for CHF Management programs and utilize these providers**

**Data Source:** Implementation plans evidence of preferred provider arrangements

**Process Milestone 3 Estimated Incentive Payment:** $94,162

### Process Milestone 4 [P-7]: Other Activities

**Implement CHF teaching program for CHF patients and families**

**Data Source:** Implementation plans evidence of preferred provider arrangements

**Process Milestone 4 Estimated Incentive Payment:** $94,163

### Outcome Improvement Target 1 [IT-3.2]: CHF 30 day readmission rate

**Improvement Target:** 3% Reduction in CHF 30 day readmission rate from baseline of 12.4%

**Data Source:** BHS STAR patient accounting and Avega systems

**Outcome Improvement Target 1 Estimated Incentive Payment:** $94,163

### Outcome Improvement Target 2 [IT-3.2]: CHF 30 day readmission rate

**Improvement Target:** 5% Reduction in CHF 30 day readmission rate from baseline of 12.4%

**Data Source:** BHS STAR patient accounting and Avega systems

**Outcome Improvement Target 2 Estimated Incentive Payment:** $722,642

### Year 2 Estimated Outcome Amount: $162,471

### Year 3 Estimated Outcome Amount: $188,325

### Year 4 Estimated Outcome Amount: $302,196

### Year 5 Estimated Outcome Amount: $722,642

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,375,634
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate
RHP Outcome Identification Number: 159156201.3.7 – PASS 1
Provider Name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201

Outcome Measure Description:

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

Process Milestones:

- DY2
  Process Milestone 1 P-7 Other Activities
  Prior to discharge secure PCP follow-up appointment scheduled within 3-7 days of discharge
  Process Milestone 2 P-4 Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities
  Review 100% of all AMI 30 day readmissions for transitional failure

- DY3
  Process Milestone 3 P- 5 Disseminate findings, including lessons learned and best practices, to stakeholders
  Share data from DY 2 readmission reviews with providers and identify correctional improvements
  Process Milestone 4 P-7 Other Activities
  Implement at least 2 new processes following review and data sharing for improved transitional care

Outcome Improvement Targets for each year:

- DY4-
  IT- 3.5 Show improvement through 3% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

- DY5-
  IT-3.5 Show improvement through 5% reduction in 30 day all cause readmissions for AMI patients over baseline rate for 12 months ending 12-31-11 which = 9.4%

Rationale:

Patients with AMI are more likely to be readmitted within 30 days as complicated by patient age, frailty and frequent comorbid conditions. The rate for readmission in post AMI patients has increased per a 2010 study in “Cardiovascular Quality and Outcomes” but is due to higher non cardiovascular complications. Bexar County has a higher incidence of comorbid conditions such as hypertension, renal failure with dialysis, COPD and diabetes. Additional factors such as
pneumonia or impeded swallowing function can also impact readmission rates.

**Process milestones:**

Process milestones 1-4 were chosen as methods for reducing preventable readmissions which reduces costs and improves quality of care and life for the patient and family. BHS will institute a care coordination process for the AMI patient focusing on a thorough “transition” from the hospital setting through partnership with other health care providers instead of simply “handing-off” the patient. Education of the patient, family, and caregivers and ensuring the timely follow-up with the primary/specialty care physician is critical for successful management in the AMI’s patients post acute status.

**Improvement target:**

Improvement targets are listed above in Outcome Description.

This is a relevant outcome measure for Category 2 Project 8 Apply Process Improvement Methodology to Improve Quality/Efficiency. Using these tools, staff and physicians can assess current processes and care patterns for improvements, collect and analyze data related to failures and adjust/implement changes for improved outcomes in managing the AMI patient for successful, post acute care transition and avoid readmissions, improve patient health status and quality of life for patient and family.

**Outcome Measure Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

Cardiovascular disease (CAD) is prevalent in the RHP 6 patient population. Comorbidities complicating CAD impact serious acute inpatient conditions such as Acute Myocardial Infarctions (AMI) and improved, successful management of AMI resulting in reduced 30 day readmissions benefits the patient, family, providers, and community by improving the patient health status, reducing costs and avoidable readmissions, thus creating greater access for the RHP 6 underserved patient population.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Process Milestone 3</th>
<th>Process Milestone 4</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-7]: Other Activities</td>
<td>[P-4]: Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities</td>
<td>[P-5] Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>[P-7] Other Activities</td>
<td>Improvement Target: 3% Reduction in AMI 30 day readmission rate from baseline of 9.4%</td>
<td>Improvement Target: 5% Reduction in CHF 30 day readmission rate from baseline of 9.4%</td>
</tr>
<tr>
<td>Prior to discharge secure PCP follow-up appointment within 3-7 days of discharge</td>
<td>Review 100% of all AMI 30 day readmissions for transitional failure</td>
<td>Share data from DY2 readmission reviews with providers, identify correctional improvements</td>
<td>Implement at least 2 new processes following review and data sharing</td>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
<td>Data Source: BHS STAR patient accounting and Avega systems</td>
</tr>
<tr>
<td>Data Source: Midas, Allscripts</td>
<td>Data Source: BHS Quality/Case Management Records</td>
<td>Data Source: Process Improvement Data Records</td>
<td>Data Source: Implementation plans</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $302,196</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $722,642</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline**: 9.4%

**Year 2** (10/1/2012 – 9/30/2013)
- Process Milestone 1 Estimated Incentive Payment: $81,236
- Process Milestone 2 Estimated Incentive Payment: $94,117

**Year 3** (10/1/2013 – 9/30/2014)
- Process Milestone 3
- Process Milestone 4

**Year 4** (10/1/2014 – 9/30/2015)
- Outcome Improvement Target 1

**Year 5** (10/1/2015 – 9/30/2016)
- Outcome Improvement Target 2
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<td>Year 2 Estimated Outcome Amount: $162,471</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,375,634**
Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Outcome ID: (TPI Pending) 3.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: Children’s Hospital of San Antonio</td>
</tr>
<tr>
<td>TPI: 020844903</td>
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</tbody>
</table>

Outcome Measure Description:

<table>
<thead>
<tr>
<th>IT-9.2 – ED appropriate utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce pediatric Emergency Department visits (CHIPRA Core Measure)</td>
</tr>
</tbody>
</table>

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish Baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-9.2 Reduce pediatric Emergency Department visits – Target to be determined.
- DY5:
  - IT-9.2 Reduce pediatric Emergency Department visits – Target to be determined.

Rationale:

The emergency department frequently becomes the focal point in the health care system when care is poorly coordinated. With shortages in many pediatric specialties, chronic disease management is a critical area of concern due to the impact it can have on ED utilization. The primary objective of project (TPI Pending) 1.3 (Pediatric Specialty Care Expansion) is to improve access by establishing pediatric specialty practices, clinics and other sites of services. By providing a more geographically dispersed network of specialty care, patients with chronic diseases will have greater access to these much needed services, which will reduce ED utilization. For this reason, improvement target ED appropriate utilization will be used as an improvement measure for this project. As stated above, improvement targets will be implemented in DY3-5. CH of SA chose the reduction in pediatric emergency cases as an outcome measure for this project because the introduction of pediatric specialties should reasonably lead to better and more available treatment, and untimely less admittance to the ED. The process milestones of developing and testing systems as well establishing a baseline rate are logistically necessary for the successful completion of the his project.

Outcome Measure Valuation:

In valuing this project, Children’s Hospital of San Antonio took into account the extent to which Pediatric Subspecialty Expansion project would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.
The RHP 6 Community Needs Assessment identified the high prevalence of chronic diseases and lack of provider shortages as two major issues facing the region. According to a recent analysis conducted by 3d Health, the San Antonio MSA alone has an estimated deficit of 20 pediatric subspecialists. The emergency department frequently becomes the focal point in the health care system when patients have trouble accessing specialty care providers. By providing a more geographically dispersed network of specialty care, Children’s Hospital of San Antonio can increase the capacity for pediatric sub-specialty care services, which will reduce unnecessary ED utilization, improve quality and efficiency and reduce costs.
### 3.IT-9.2 ED Appropriate Utilization

<table>
<thead>
<tr>
<th>(TPI Pending). 3.1 PASS 1</th>
<th>3.IT-9.2 ED Appropriate Utilization</th>
<th>TPI - 020844903</th>
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<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline to be established in DY3</td>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-3]: Develop and Test Systems</td>
<td>Process Milestone 2 [P2]: Establish baseline rates Data Source: EHR or Horizon’s Business Insights</td>
<td>Outcome Improvement Target 1 IT-9.2: ED Appropriate Utilization: Reduce Pediatric Emergency Department visits. Improvement Target</td>
<td>Outcome Improvement Target 2 IT-9.2: ED Appropriate Utilization: Reduce Pediatric Emergency Department visits. Improvement Target</td>
</tr>
<tr>
<td>Data Source: EHR or Horizon’s Business Insights</td>
<td>Process Milestone 2 Estimated Incentive Payment: $284,324</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $528,843</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,264,624</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $284,324</td>
<td>Year 3 Estimated Outcome Amount: $329,569</td>
<td>Year 4 Estimated Outcome Amount: $528,843</td>
<td>Year 5 Estimated Outcome Amount: $1,264,624</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,407,360**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate Utilization
Unique RHP Outcome ID: (TPI Pending)3.2 – PASS 1
Performing Provider: Children’s Hospital of San Antonio
TPI: 020844903

Outcome Measure Description:

IT-9.2 – ED appropriate utilization
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)

Process Milestones:
- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish Baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-9.2 Reduce pediatric Emergency Department visits – Target to be determined
- DY5:
  - IT-9.2 Reduce pediatric Emergency Department visits – Target to be determined

Rationale:

According to a recent physician demand analysis, there is an estimated shortage of 40 pediatricians in Bexar County. This shortage of pediatricians can cause significant access issues, forcing parents/guardians to use the ED as their child’s primary care provider for acute illness management and preventative care needs. The primary goal of project (TPI Pending)1.4 (Pediatric Primary Care expansion) is to help established practices expand, replace retiring physicians, and add new practices in areas with significant access issues. The ED Appropriate Utilization improvement target is an accurate measure for determining the impact this increased access has on ED utilization. As stated above, improvement targets will be implemented in DY3-5. The reduction of pediatric emergency room visits is a reasonable measure of the success of this program because the access to primary care that will be the result of this project can reasonably expect to reduce ED admissions. Additionally, the two process milestones selected are logistically necessary to implement this project.

Outcome Measure Valuation:

In valuing this project, Children’s Hospital of San Antonio took into account the extent to appropriate ED utilization would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The RHP 6 Community Needs Assessment identified the lack of provider shortages as two major issues facing the region. According to a recent analysis conducted by 3d Health, Bexar County alone has an estimated deficit of 40 pediatricians. The emergency department frequently becomes the focal point in the health care system when patients have trouble accessing primary care. By providing a more geographically dispersed network of pediatric primary care services,
Children’s Hospital of San Antonio can increase the capacity for these services, which will reduce unnecessary ED utilization, improve quality and efficiency and reduce costs.
<table>
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<tr>
<th>(TPI Pending).3.2 PASS 1</th>
<th>3.IT-9.2</th>
<th>ED Appropriate Utilization</th>
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<td>TPI - 020844903</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td>Process Milestone 1 [P-3]: Develop and Test Systems Data Source: EHR or Horizon Business Insights</td>
<td>Process Milestone 2 [P2]: Establish baseline rates Data Source: EHR or Horizon Business Insights</td>
<td>Outcome Improvement Target 1 IT-9.2: ED Appropriate Utilization Improvement Target: TBD Data Source: EHR or Horizon Business Insights</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $284,324</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,407,360
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome ID: 020844901.3.1 – PASS 1
Performing Provider: CHRISTUS Santa Rosa Health System
TPI: 020844901

Outcome Measure Description:
IT-9.2 – ED appropriate utilization

• Reduce all ED visits

Process Milestones:
• DY2:
  o P-3 – Develop and test data systems
• DY3:
  o P-2 – Establish Baseline rates

Outcome Improvement Targets for each year:
• DY4:
  o IT-9.2 Reduce the number of unnecessary emergency department visits - Target to be determined.
• DY5:
  o IT-9.2 Reduce the number of unnecessary emergency department visits - Target to be determined.

Rationale:
The growing shortage of primary care workforce personnel in Texas is a critical problem that has contributed to increased wait times in hospitals, community clinics, and other care settings. Patients with non-emergent issues are using the ED for their primary care needs, which is a costly burden to the health care system. The primary goal of project 020844901.1.2 is to expand access by adding an additional clinic and hiring additional primary care providers, which will help address this substantial shortage, therefore giving patients a less costly alternative to the ED. As stated above, improvement targets will be implemented in DY3-5.

Outcome Measure Valuation:
In valuing this project, CHRISTUS Santa Rosa took into account the extent to which appropriate ED utilization would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The inappropriate use of EDs (particularly as sites of primary care) is a pervasive inefficiency in the healthcare delivery system adding a costly burden to the health care system. By reducing inappropriate use of EDs, CHRISTUS Santa Rosa can help lower the cost of healthcare in the community and in the State, and free up healthcare emergency healthcare resources for patients who truly need them.
<table>
<thead>
<tr>
<th>020844901.3.1 PASS 1</th>
<th>3.IT-9.2</th>
<th>ED Appropriate Utilization</th>
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<tr>
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<td>Starting Point/Baseline:</td>
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<td>Process Milestone 2 [P2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 IT-9.2: ED Appropriate Utilization</td>
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<td>Data Source: EHR/Horizon Business Insights</td>
<td>Data Source: EHR/Horizon Business Insights</td>
<td>Improvement Target: TBD Data Source: EHR/Horizon Business Insights</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $189,549</td>
<td>Process Milestone 2 Estimated Incentive Payment: $219,713</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $352,562</td>
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<td>Year 2 Estimated Outcome Amount: $189,549</td>
<td>Year 3 Estimated Outcome Amount: $219,713</td>
<td>Year 4 Estimated Outcome Amount: $352,562</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,604,907
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-1.10 Diabetes Care: HbA1c Poor Control</th>
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<tr>
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<tr>
<td>TPI:</td>
<td>020844901</td>
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</table>

### Outcome Measure Description:

### IT-1.10 – Diabetes Care: HbA1c Poor Control

- Percentage of patients 65 to 75 years of age with diabetes (Type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9%.

### Process Milestones:

- **DY2:**
  - P-3 – Develop and test data systems

- **DY3:**
  - P-2 – Establish Baseline rates

### Outcome Improvement Targets for each year:

- **DY4:**
  - IT-1.10 decrease the percentage of patients 65 to 75 years of age with diabetes (Type 1 or type 2) who have HbA1c control >9% - % to be determined.

- **DY5:**
  - IT-1.10 decrease the percentage of patients 65 to 75 years of age with diabetes (Type 1 or type 2) who have HbA1c control >9% - % to be determined.

### Rationale:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. In addition, other chronic conditions are common among people with diabetes and account for much of the morbidity these patients face. Comorbidities can have profound effects on patients’ ability to manage their self-care. A major goal of Project 020844901.2.4 (Patient-Centered Medical Home) is to improve adherence to care plans by offering comprehensive preventative and primary care services that cater to the complex, chronic care needs of the population 65 and older. This outcome measure will track the progress of the Medical Home project because it gauges the management of one of the most prevalent chronic diseases in the community. The process milestones selected are necessary to logistically implement the project. CHRISTUS needs a baseline and data in order to measure the outcome.

### Outcome Measure Valuation:

In valuing this project, CHRISTUS Santa Rosa took into account the extent to which the appropriate management of diabetes in the 65-75 year old population would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Through better management of diabetes in the, CHRISTUS Santa Rosa can ensure patient compliance with managing their diabetes, resulting in improved HbA1C levels, which ultimately
drives improved outcomes.
<table>
<thead>
<tr>
<th>020844901.3.2 PASS 1</th>
<th>3.IT-1.10</th>
<th>Diabetes Care: HbA1c Poor Control</th>
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<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<td>Process Milestone 1 [P-3]: Develop and Test Systems Data Source: Horizon Business Insights</td>
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<td>Outcome Improvement Target 1 IT-1.10: Diabetes Care: HbA1c Poor Control Improvement Target: TBD Data Source: Horizon Business Insights</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $189,549</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,604,907**
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate
Unique RHP Outcome ID: 020844901.3.3 – PASS 1
Performing Provider: CHRISTUS Santa Rosa Health System
TPI: 020844901

Outcome Measure Description:
IT-3.2 – Congestive Heart Failure 30 day readmission rate

- The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission.

Process Milestones:
- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish Baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-3.2. decrease the number of admissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission – Target to be determined
- DY5:
  - IT-3.2. decrease the number of admissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission - Target to be determined

Rationale:
Monitoring the potentially preventable readmission rates for Congestive Heart Failure is a key indication and barometer of ongoing healthcare improvements in the community. During the last decades, heart failure treatment has improved rapidly. There are now a number of drugs recommended along with non-pharmacological interventions such as changes in lifestyle and monitoring of symptoms to improve mortality and morbidity in patients with heart failure. The responsibility of health care professionals is to prescribe treatment according to guidelines and to dedicate additional time and effort to encourage and support patient to comply with a multi-faceted treatment program. Congestive Heart Failure is one of the principal diagnoses that will be targeted by the care transitions program, which makes improvement target IT-3.2 Congestive Heart Failure 30-Day Readmission Rate a suitable measurement for this project. As stated above, improvement targets will be implemented in DY3-5. The process milestones were chosen because they are logistically necessary for the successful implementation of this project. Specifically, data and a baseline are both necessary components to measure he reduction in CHF readmissions.
**Outcome Measure Valuation:**

In valuing this project, CHRISTUS Santa Rosa took into account the extent to which the reduction in potentially preventable readmissions due to Congestive Heart Failure would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

According to the RHP 6 Community Needs Assessment, there is a high prevalence of chronic disease and related health disparities that require greater prevention efforts and management. By reducing the unplanned re-admissions for the target population with congestive heart failure and target those with pneumonia and acute myocardial infarction CHRISTUS Santa Rosa will be adding significantly to the quality of life and the health outcomes of this population. These conditions are increasingly common in an aging population, are associated with substantial mortality and morbidity, and have considerable variation in outcomes across U.S. hospitals. A reduction in hospital readmission rates will be a reliable indicator of improved health status for this population.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020844901.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be established in DY3</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;[P-3]: Develop and Test Systems</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;[P2]: Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $189,549</td>
<td>Process Milestone 2 Estimated Incentive Payment: $219,713</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-3.2: Congestive Heart Failure 30 day Readmission Rate</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-3.2: Congestive Heart Failure 30 day Readmission Rate</td>
</tr>
<tr>
<td></td>
<td>Improvement Target: TBD</td>
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<td></td>
<td>Data Source: EHR</td>
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<tr>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $352,562</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $843,083</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $189,549</td>
<td>Year 3 Estimated Outcome Amount: $219,713</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,604,907
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-2.13 Behavioral Health Admission Rate for Youth. This is a custom/optional measure ONLY because measure 2.4 is designed for patients 18 and over. Our measure is for children ages 3-17 in the service area. Specific information on the numerator and denominator are noted in narrative and in the table.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Outcome ID:</td>
<td>112742503.3.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Clarity Child Guidance Center</td>
</tr>
<tr>
<td>TPI:</td>
<td>112742503</td>
</tr>
</tbody>
</table>

## Outcome Measure Description:

- **IT 2.13 Behavioral Health Admission Rate for Youth**

  The numerator would include discharges where the primary and secondary diagnosis was behavioral health from our acute, inpatient hospital. This would be applied against a denominator of all youth 3-17 who received any service following assessment, including a referral, individual, family or group therapy, medication evaluation, medication management, psychological assessment and/or consultation or partial hospitalization as alternatives to acute care hospitalization. A baseline would be established in DY3, and reporting would commence in DY4, with improvements TBD based on the data analyzed in DY3. This measure was required to be optional primarily because the other preventable admissions measures applied to patients 18 and over, and our focus is children and adolescents. Clarity Child Guidance Center currently provides services for approximately 7,000 children. Some of those children who are assessed are admitted to our acute inpatient hospital, while others require partial hospitalization or outpatient therapy. Our goal is to provide the right care in the right setting, thereby offering a continuum of services. Today, 1,300 children and adolescents present at local emergency rooms with no access to psychiatric care at that facility. We anticipate screening >300 patients annually who divert to our regional psychiatric service.

  A request was sent to HHSC on 10/1/12, follow-up on 10/2/12 and 10/3/12 about the appropriate measure to utilize. University Health System was copied on all requests.

  **Process Milestones:**

  - **DY2:**
    - P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **DY3:**
    - P-2 Establish baseline rates
      - IT-2.13: Behavioral Health Admission Rate for Youth; decrease admissions by TBD percentage below baseline

  **Outcome Improvement Targets for each year:**

  - **DY4:**
    - IT-2.13: Behavioral Health Admission Rate for Youth; decrease admissions by TBD percentage below baseline
  - **DY5:**
    - IT-2.13: Behavioral Health Admission Rate for Youth; decrease admissions by TBD percentage below baseline
### Rationale:

Process milestones P-1 and P-2 were chosen to effectively address reporting requirements, by creating solid processes and then establishing baselines. The process milestones also align with milestones indicated in Category 1, creating synergy in the Plan Do Study Act processes. P-1 will be approached in DY2, with DY3 creating baseline rates in order to report on outcomes in the latter part of DY3, and full year reporting in DY4 and DY5.

The creation of a children’s psychiatric emergency service located at Clarity Child Guidance Center will increase access to multiple treatment options and support the philosophy of the “right care, right setting”. Rather than the estimated 1,300 children and adolescents presenting at local emergency departments that do not provide psychiatric care and being “boarded” for an average of 12 hours, youth would present at our facility for an appropriate assessment. Many times, in the triage and assessment process, other less intensive treatment options can be provided, such as outpatient therapy or day treatment. These options would reduce hospital admissions, the key outcome metric noted within IT 2.4, which was customized as 2.13 to measure youth admissions.

### Outcome Measure Valuation:

The approach calculating values for milestones is based on our decades of service to children ages 3-17 with mental health problems. We are affiliated with The University of Texas Health Science Center’s Department of Psychiatry and plan to expand the affiliation to the Department of Pediatrics in order to integrate care.

Children served through our triage approach to care, resulting in “right care, right setting” will save local hospitals countless dollars. As an example, most Emergency Departments can turn an ER bed within a 2-hour window, versus “boarding” psychiatric patients ages 3-17 for an average of 12 hours. A child with a mental health crisis presenting at a local hospital for ED services is far more costly than our “right care, right setting” approach, even if the child is admitted for acute psychiatric services. However, we believe that a significant percentage of patients presenting to us can be diverted to less intensive behavioral health treatment services, such as outpatient therapy or day treatment.

Our project also aligns with the Community Needs Assessment, specifically to the following identification areas:

- **CN.1** Texas ranks last in the nation on health care quality.
- **CN.2** Many residents of RHP 6 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.
- **CN.4** There is a shortage of high quality mental and behavioral health services that are integrated with physical health services and/or provide crisis stabilization.

Local funding will occur through our IGT partner, University Health System, and through self-funding.

Note: During dialogue with HHSC, we would have benefited from the utilization of the OD-9 outcome measures for “right care, right setting”. However, the measure uses “member months” as part of the calculation and that approach is for managed care and not a typical measure used with hospitals.
### Potential Preventable Admissions - Behavioral Health Youth Admission Rate

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>112742503.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 (P-1):</td>
<td>Process Milestone 2 (P-2):</td>
</tr>
<tr>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: PMP Project Management approach.</td>
<td>Data Source: Electronic Medical Records of all youth 3-17 seen with a primary or secondary diagnosis of behavioral health that are discharged from our acute care hospital (numerator) against all patients assessed, where a service was provided such as a referral, individual, family or group therapy, medication evaluation, medication management, psychological assessment and/or consultation or partial hospitalization were provided as an alternative to acute care hospitalization (denominator).</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $82,933</td>
<td>Milestone 2 Estimated Incentive Payment: $96,161</td>
</tr>
</tbody>
</table>

**Clarity Child Guidance Center**

| 112742503.3.1 PASS 1 | 3. IT-2.13 | TPI - 112742503 |

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**Clarity Child Guidance Center**

1112 ★ RHP 6 Plan ★ March 8, 2013
<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $82,933</th>
<th>Year 3 Estimated Milestone Bundle Amount: $96,161</th>
<th>Year 4 Estimated Milestone Bundle Amount: $154,256</th>
<th>Year 5 Estimated Milestone Bundle Amount: $368,873</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $702,223
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure: IT-1.6 Cholesterol Management for patients with Cardiovascular Conditions</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number: 135151206.3.1 – PASS 1</td>
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<tr>
<td>Performing Provider: Connally Memorial Medical Center</td>
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<tr>
<td>TPI: 135151206</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

| Outcome Measure Description: |
| IT-1.6 Cholesterol Management for patients with Cardiovascular Conditions |

### Process Milestones:

| DY2: |
| 1. P-1 - Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans |

| DY 3: |
| 1. P-2 – Establish Baseline rates |
| 2. P-3 – Develop and test data systems |

| DY-4 |
| 1. IT-1.6: Increase in percentage of patients receiving LDL-C screening test and LDL-C level less than 100mg/dL (Target TBD) |

| DY-5 |
| 1. IT-1.6: Increase in percentage of patients receiving LDL-C screening test and LDL-C level less than 100mg/dL (Target TBD) |

### Rationale:

Process milestones P-1 through P-3 were chosen due to the lack of accurate reports currently available to monitor and manage cholesterol levels for patients at Connally Memorial Medical Center. In order to report accurate data and establish baselines, P-1, P-2 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines and test data systems.

Improvement targets were chosen for DY4 and DY5 based on research of similar interventions and recommended guidelines. These guidelines include the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. The outcome measures being addressed can largely be affected by lifestyle factors as well as new medications that offer tangible means for reducing cholesterol and the risk of heart disease.
### Outcome Measure Valuation:

One of the community needs addressed in our RHP Plan is that the high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Additionally, the leading causes of death in Wilson county are related to cardiovascular conditions (30% of all deaths) and heart diseases (24%). This project and associated outcomes’ focus on disease management and risk reduction allows Connally Memorial Medical Center the opportunity to achieve our RHP goals of Improves outcomes while containing cost growth. This project will also help meet our goal to assure patients receive high-quality and patient-centered care in the most cost effective way.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>135151206.1.1</th>
<th>Connally Memorial Medical Center</th>
<th>TPI - 135151206</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
<td></td>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2</strong> [P-2]: Establish Baseline rates</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-1.6]: Improvement Target: Increase in percentage of patients receiving LDL-C screening test and LDL-C level less than 100mg/dL</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-1.6]: Improvement Target: Increase in percentage of patients receiving LDL-C screening test and LDL-C level less than 100mg/dL</td>
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<tr>
<td>Data Source: EMR; Documentation of plans, stakeholder meetings</td>
<td>Process Milestone 2 Estimated Incentive Payment: $38,413</td>
<td>Data Source: EMR</td>
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<td>Year 2 Estimated Outcome Amount: $66,279</td>
<td>Year 3 Estimated Outcome Amount: $76,826</td>
<td>Year 4 Estimated Outcome Amount: $123,280</td>
<td>Year 5 Estimated Outcome Amount: $294,799</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $561,184
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure: IT-6.1 Percent improvement over baseline of Patient Satisfaction scores
Unique RHP outcome identification number: 135151206.3.2 – PASS 2
Provider name: Connally Memorial Medical Center
TPI: 135151206

Outcome Measure Description:

Outcome Measure Description:
IT-6.1 Percent improvement over baseline of Patient Satisfaction scores

Process Milestones:

DY2:
2. P-1 - Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY 3:
3. P-2 – Establish Baseline rates
4. P-3 – Develop and test data systems

DY-4
1. IT-6.1: Increase in patient satisfaction scores for one or more of the patient satisfaction domains (Target TBD)

DY-5
1. IT-6.1: Increase in patient satisfaction scores for one or more of the patient satisfaction domains (Target TBD)

Rationale:

Process milestones P-1 through P-3 were chosen due to the lack of accurate reports currently available to monitor and patient satisfaction scores throughout the entire organization, including outpatient services. In order to report accurate data and establish baselines, P-1, P-2 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines and test data systems.

Improvement targets were chosen for DY4 and DY5 in order to produce comparable data on the patient’s perspective of care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Outcome Measure Valuation:

One of the community needs addressed in our RHP Plan is that the high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Additionally, the leading causes of death in Wilson county are related to cardiovascular conditions (30% of all deaths) and heart diseases (24%). Patient satisfaction with healthcare services is largely related to the utilization of these services. Understanding strengths, needs and receiving patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patient’s needs.
<table>
<thead>
<tr>
<th>Date: March 8, 2013</th>
<th>Connally Memorial Medical Center</th>
<th>TPI - 135151206</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<td>To be developed in DY3</td>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong>: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-2]</strong>: Establish Baseline rates</td>
<td><strong>Outcome Improvement Target 1 [IT-1.6]</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-1.6]</strong></td>
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<td>Data Source: EMR; Documentation of plans, stakeholder meetings</td>
<td>Data Source: EMR</td>
<td>Improvement Target: Increase in patient satisfaction scores for one or more of the patient satisfaction domains</td>
<td>Improvement Target: Increase in patient satisfaction scores for one or more of the patient satisfaction domains</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $17,651</td>
<td>Process Milestone 2 Estimated Incentive Payment: $10,246</td>
<td>Data Source: Survey</td>
<td>Data Source: Survey</td>
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<tr>
<td><strong>Process Milestone 3 [P-3]</strong>: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $32,997</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $78,811</td>
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<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $10,246</td>
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</table>

- Year 2 Estimated Outcome Amount: $17,651
- Year 3 Estimated Outcome Amount: $20,492
- Year 4 Estimated Outcome Amount: $32,997
- Year 5 Estimated Outcome Amount: $78,811

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $149,951**
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure)
Unique RHP outcome identification number: 112690603.3.1 - PASS 1
Performing Provider: Dimmit Regional Hospital
TPI: 112690603

Outcome Measure Description:
IT-6.1- Percent improvement over baseline of patient satisfaction.
Measures the percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.
- Rate 1: (3) patient’s rating of doctor access to a specialist. Percent improvement TBD in DY 3 using DY 2 baseline data.

Process Milestones:
- DY2:
  - P-1 – Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-2 – Establish baseline rates for rate 1

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1 Rate 1: (3) – Improve patient’s rating of doctor access to a specialist. Percentage improvement or point increase expected will be set after the completion of process milestone 4 [P-2] in DY 3
- DY5:
  - IT-6.1 Rate 1: (3) – Improve patient’s rating of doctor access to a specialist. Percentage improvement or point increase expected will be set after the completion of process milestone 4 [P-2] in DY 3

Rationale:
Process Milestones – DY 2: P-1 was chosen because a project similar to this project has never been implemented in the past. There is a great need for stakeholder engagement in the development and support of a 4 year project plan to ensure achievement of Cat. 3 improvement targets. This plan will provide the foundation and vision for achievement of the improvement targets in DY 4-5. The accomplishment of P-3 during DY 2 is necessary for accurate completion of P-4 and P-2 in DY 3. Ensuring that data systems have been developed, tested, and are reliable is vital to the accuracy of the reported numbers and success of the project. DY 3: Completion of P-4 is necessary for accurate and efficient data collection. Achievement of this milestone will improve the data collection process through identifying collection practices/data prone to error and recommending necessary changes. P-2 achievement will allow accurate improvement targets to be set for IT-6.1 in DY 4 and DY 5.
Improvement Targets – Outcome improvement targets for DY 4-5 were chosen based on their ability to accurately assess the performance and impact of the associated category 1 project 112690603.1.9 from the perspective of the patient (OD-6). Patient satisfaction, specifically with regard to access to specialty care, is important to measure as this is the exact community need DRH desires to meet. In other words, DRH desires to increase and improve rural access to specialty care in its service region. There is not a Cat.3 outcome measure that reflects fulfillment of this goal better than IT-6.1. This improvement target is centered on the patient’s perception of access and care. Also, the impact of cycle time and provider productivity improvements achieved by P-17 in DY 4 and DY 5 is also reflected in specialty care patient satisfaction scores – (3) patient’s rating of doctor access to a specialist

Outcome improvement targets with their specific percentage or point increases in patient satisfaction scores will be determined in DY 3 after the accomplishment of P-2.

Outcome Measure Valuation:

The outcome measure and associated improvement target below were valued based on how closely associated the measure was with the chosen project. Additional methods used to value the project hinged on the valuation methodology weights provided by the RHP 6 Anchor facility, University Health System. The valuation methodology included across four categories: Achieves Waiver Goals, Addresses Community Needs(s), Project Scope and Project Investment. This outcome measure received the highest score across all categories

Patient satisfaction is difficult if not impossible to value on a cost avoidance basis. However, DRH is of the opinion that increases in patient satisfaction scores will have the greatest impact on access to quality healthcare for the region. It is the only measure which completely ensures care is “patient-centered” and meets the waiver goals.
<table>
<thead>
<tr>
<th>Project Number</th>
<th>Description</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112690603.3.1</td>
<td>PASS 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure) (3)—patient’s rating of doctor access to specialist.</td>
<td>Dimmit Regional Hospital</td>
<td>112690603.1.1</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<td>To be developed in DY 3</td>
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<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
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<td>Year 5 Estimated Outcome Amount: $873,391</td>
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</table>
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,915,956
**Identifying Outcome Measure and Provider Information:**

Title of Outcome Measure (Improvement Target): IT-9.2 Reduce all ED visits (including ACSC)

Unique RHP outcome identification number: 112690603.3.2 – PASS 2

Provider Name: Dimmit Regional Hospital

TPI: 112690603

**Outcome Measure Description:**

IT-9.2: Reduce all ED visits (including ACSC)

**Process Milestones:**

- **DY2:**
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources
  - P-3: Develop and test data systems

- **DY3:**
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-2: Establish baseline rates

**Outcome Improvement Targets for each year:**

- **DY4:**
  - IT-9.2 Reduce unnecessary ED visits or ED visits by patients with non-emergent conditions. The actual % reduction in ED visits will be determined in DY 3 after the completion of process milestone 4 [P-2].

- **DY5:**
  - IT- Reduce unnecessary ED visits or ED visits by patients with non-emergent conditions. The actual % reduction in ED visits will be determined in DY 3 after the completion of process milestone 4 [P-2].

**Rationale:**

Process Milestones – DY 2: P-1 was chosen because a project similar to this project has never been implemented in the past. There is a great need for stakeholder engagement in the development and support of a 4 year project plan to ensure achievement of Cat. 3 improvement targets. This plan will provide the foundation and vision for achievement of the improvement targets in DY 4-5. The accomplishment of P-3 during DY 2 is necessary for accurate completion of P-4 and P-2 in DY 3. Ensuring that data systems have been developed, tested, and are reliable is vital to the accuracy of the reported numbers and success of the project. DY 3: Completion of P-4 is necessary for accurate and efficient data collection. Achievement of this milestone will improve the data collection process through identifying collection practices/data prone to error and recommending necessary changes. P-2 achievement will allow accurate improvement targets to be set for IT-6.1 in DY 4 and DY 5.

Improvement Targets – Outcome improvement targets for DY 4-5 were chosen based on their ability to accurately assess the performance and impact of the associated category 1 project 112690603.1.2. There is not a Cat.3 outcome measure that measures performance of the associated Cat. 1 project better than IT-9.2. This improvement target will reduce costs for patients and for the Medicare program. A decrease in the average number of ED visits will ensure this cost reduction and ensure that the right care is occurring in the right setting.
Utilization of an urgent medical advice line with an ED fast track system (cat. 1 project) will reduce the number of ED visits while reducing cycle time (ED wait time) and improving provider productivity.

The actual % reduction in ED visits will be determined in DY 3 after the completion of process milestone 4 [P-2].

**Outcome Measure Valuation:**

The outcome measure and associated improvement target below were valued based on how closely associated the measure was with the chosen project. Additional methods used to value the project hinged on a valuation methodology. The valuation methodology included across four categories: Achieves Waiver Goals, Addresses Community Needs(s), Project Scope and Project Investment. This outcome measure received the highest score across all categories.

Dimmit Regional Hospital also values each outcome based on the following factors: the potential impact on health of our population, the resources necessary to achieve the outcome, and level of improvement anticipated in overall patient satisfaction. Dimmit Regional Hospital also took into account the extent to which reducing ED waiting times and reducing the volume of non-emergent ED patient visits would potentially meet the goals of the region and the Waiver.
<table>
<thead>
<tr>
<th>112690603.3.2 PASS 2</th>
<th>3.IT-9.2</th>
<th>Reduce all ED visits (including ACSC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimmit Regional Hospital</td>
<td>TPI - 217884001</td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

112690603.1.2

**Starting Point/Baseline:**

To be developed in DY 3

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources</td>
<td><strong>Process Milestone 3</strong> [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-9.2]: Reduce all ED visits (including ACSC)</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-9.2]: Reduce all ED visits (including ACSC)</td>
</tr>
<tr>
<td>Data Source: Documentation of meetings held, attendance sheets and documented recommendations.</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 23,295</td>
<td>Improvement Target: Reduce unnecessary ED visits or ED visits by patients with non-emergent conditions. The actual % reduction in ED visits will be determined in DY 3 after the completion of process milestone 4 [P-2].</td>
<td>Improvement Target: Reduce unnecessary ED visits or ED visits by patients with non-emergent conditions. The actual % reduction in ED visits will be determined in DY 3 after the completion of process milestone 4 [P-2].</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 20,066.50</td>
<td>Process Milestone 4 Estimated Incentive Payment: $ 23,295</td>
<td>Data Source: Patient records, ED documentation and records</td>
<td>Data Source: Patient records, ED documentation and records</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 75,026</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 179,193</td>
<td></td>
</tr>
<tr>
<td>Data Source: Business Intelligence, IT documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $ 20,066.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-9.2]: Reduce all ED visits (including ACSC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 40,133</td>
<td>Year 3 Estimated Outcome Amount: $ 46,590</td>
<td>Year 4 Estimated Outcome Amount: $ 75,026</td>
<td>Year 5 Estimated Outcome Amount: $ 179,193</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $340,942**
<table>
<thead>
<tr>
<th>Identifying Outcome Measure and Provider Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Outcome Measure (Improvement Target):</strong> 3.IT – 1.12 Diabetes Care: Retinal eye exam</td>
</tr>
<tr>
<td><strong>Unique RHP Outcome ID #:</strong> 112688002.3.1 – PASS 1</td>
</tr>
<tr>
<td><strong>Frio Regional Hospital</strong></td>
</tr>
<tr>
<td><strong>TPI:</strong> 112688002</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Measure Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This measure includes diabetic patients who had:</td>
</tr>
<tr>
<td>- a retinal or dilated eye exam; or</td>
</tr>
<tr>
<td>- a negative retinal exam</td>
</tr>
<tr>
<td>The denominator is members 18-75 years old with diabetes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The measure was selected due to the high incidence of diabetes in both Frio County and RHP 6. Frio County has a 32% adult obesity rate, low access to healthy foods, an elderly population, a 25% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors ALL lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.</td>
</tr>
</tbody>
</table>

Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Frio County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as blindness, can be prevented with early screening and detection. Diabetes screening can improve the health outcomes of a substantial amount of residents in Frio County.

Our goal is increased eye exams (retinal or dilated eye exams) in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare MRH to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Medina County...
residents. Baseline rates must be established to allow for the measurement of progress in the screening compliance of retinal eye exams.

**Outcome Measure Valuation:**

Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Frio County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Frio County living with diabetes, the cost savings and improved quality of life certainly justifies this project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>112688002.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
</tr>
<tr>
<td>P-1 Project Planning</td>
<td>P-2 Establish Baseline Rates</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $45,601</td>
<td>Process Milestone 2 Estimated Incentive Payment: $52,857</td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>IT-1.12</td>
<td>IT-1.12</td>
</tr>
<tr>
<td>Improvement Target: Increase the percent of qualified patients who receive a retinal or dilated exam or a negative exam in the prior year.</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a retinal or dilated exam or a negative exam.</td>
</tr>
<tr>
<td>Goal: TBD</td>
<td>Goal: TBD</td>
</tr>
<tr>
<td>Data Source: Electronic Health Record</td>
<td>Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $56,545</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $67,608</td>
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</tbody>
</table>

| Year 2 Estimated Outcome Amount: $45,601 | Year 3 Estimated Outcome Amount: $52,857 | Year 4 Estimated Outcome Amount: $56,545 | Year 5 Estimated Outcome Amount: $67,608 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $222,611**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): 3.IT – 1.13 Diabetes Care: Foot Exam |
|----------------------------------|----------------------------------|
| Unique RHP Outcome ID # 112688002.3.2 – PASS 1 |
| Frio Regional Hospital            |
| TPI: 112688002                    |

**Outcome Measure Description:**

This measure includes diabetic patients who received a foot exam (visual, sensory or pulse) during the measurement year.

The denominator is the number of patients 18-75 years old who have a diagnosis of diabetes.

The process measurements selected are: P-1 Project Planning and P-2 Establish Baseline Rates.

**Rationale:**

The measure was selected due to the high incidence of diabetes in both Medina County and RHP 6. Frio County has a 32% adult obesity rate, low access to healthy foods, an elderly population, a 25% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors ALL lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Frio County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as amputations, can be prevented with early screening and detection. Diabetes screening can improve the health outcomes of a substantial amount of residents in Frio County.

Our goal is increased eye exams (retinal or dilated eye exams) in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare FRH to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Medina County.
baseline rates must be established to allow for the measurement of progress in the screening compliance of retinal eye exams.

Outcome Measure Valuation:

Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Frio County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Frio County living with diabetes, the cost savings and improved quality of life certainly justifies this project.
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<thead>
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<th>Related Category 1 or 2 Projects:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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</tr>
</tbody>
</table>

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-1 Project Planning</td>
<td>P-2 Establish Baseline Rates</td>
<td>IT 1.13</td>
<td>IT 1.13</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a foot exam.</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a foot exam.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $45,601</td>
<td>Process Milestone 2 Estimated Incentive Payment: $52,857</td>
<td>Data Source: Electronic Health Record</td>
<td>Data Source: Electronic Health Record</td>
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<tr>
<td>Goal: TBD</td>
<td>Goal: TBD</td>
<td>Goal: TBD</td>
<td>Goal: TBD</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $56,545</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $67,608</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $45,601 | Year 3 Estimated Outcome Amount: $52,857 | Year 4 Estimated Outcome Amount: $56,545 | Year 5 Estimated Outcome Amount: $67,608 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $222,611**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): 3.IT – 1.14 Diabetes Care: Microalbumin/Nephropathy
Unique RHP Outcome ID #112688002.3.3 – PASS 1
Frio Regional Hospital
TPI: 112688002

Outcome Measure Description:

This measure includes diabetic patients who had a nephropathy screening test or evidence of nephropathy. The denominator is the number of patients 18-75 years old who have evidence of nephropathy or a nephropathy screening. The baseline will be established and outcome numbers for DY4 and DY5 will be determined.

The process measurements selected are: P-1 Project Planning and P-2 Establish Baseline Rates.

Rationale:

The measure was selected due to the high incidence of diabetes in both Frio County and RHP 6. Frio County has a 32% adult obesity rate, low access to healthy foods, an elderly population, a 25% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors all lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Frio County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as kidney failure, can be prevented with early screening and detection.

Diabetes screening can improve the health outcomes of a substantial amount of residents in Frio County. Our goal is increased eye exams (retinal or dilated eye exams) in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare FRH to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include
physicians, mid-level providers, staff, management, administration, and Frio County residents. Baseline rates must be established to allow for the measurement of progress in the screening compliance of retinal eye exams.

**Outcome Measure Valuation:**

Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Frio County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Frio County living with diabetes, the cost savings and improved quality of life certainly justifies this project.
### 3.IT-1.14 Diabetes Care: Microalbumin/Nephropathy

**Frio Regional Hospital**

**Related Category 1 or 2 Projects:**

112688002.3.3

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
<th><strong>Year 4</strong></th>
<th><strong>Year 5</strong></th>
</tr>
</thead>
</table>

#### Process Milestone 1

**P-1 Project Planning**

- **Data Source:** Planning Document
- **Process Milestone 1 Estimated Incentive Payment:** $45,601

#### Process Milestone 2

**P-2 Establish Baseline Rates**

- **Data Source:** Electronic Health Record
- **Process Milestone 2 Estimated Incentive Payment:** $52,857

#### Outcome Improvement Target 1

**IT 1.14 Improvement Target:** Increase the percent of qualified patients who had a nephropathy screening test or evidence of nephropathy.

- **Data Source:** Electronic Health Record
- **Goal:** TBD
- **Outcome Improvement Target 1 Estimated Incentive Payment:** $56,545

#### Outcome Improvement Target 2

**IT 1.14 Improvement Target:** Increase the percent of qualified patients who had a nephropathy screening test or evidence of nephropathy.

- **Data Source:** Electronic Health Record
- **Goal:** TBD
- **Outcome Improvement Target 2 Estimated Incentive Payment:** $67,608

**Year 2 Estimated Outcome Amount:** $45,601

**Year 3 Estimated Outcome Amount:** $52,857

**Year 4 Estimated Outcome Amount:** $56,545

**Year 5 Estimated Outcome Amount:** $67,608

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $222,611
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Outcome Measure (Improvement Target): IT – 3.2 Congestive Heart Failure 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Outcome ID #112688002.3.4 – PASS 2</td>
</tr>
<tr>
<td>Provider Name: Frio Regional Hospital</td>
</tr>
<tr>
<td>TPI: 112688002</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

This measure focuses on reducing the readmission rate for those patients with a diagnosis of congestive heart failure. The numerator is the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index of heart failure admission. The denominator is the number of admissions (for patients 18 years and older) for patients discharged from the hospital with a principle diagnosis of heart failure and with a complete claims history for the 12 months prior to admission. The baseline will be established and outcome numbers for DY4 and DY5 will be determined.

### Rationale:

The measure was selected due to the high incidence of documented heart failure in both Frio County and RHP 6. There are many factors which influence this. Frio County has a 32% adult obesity rate, low access to healthy foods, an elderly population, a 25% uninsured population, a lower per capita income, a high level of diabetes and a high percentage of Hispanics. The above factors all lead to an increased prevalence of heart failure. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement in assessing patients with heart failure will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access to specialists as well as primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Frio County. Improved access to providers will lead to increased visits and therefore increased screenings. Heart failure is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications and readmissions can be prevented with early screening and detection, as well as life style changes. Better assessment of heart failure patients can improve the health outcomes of a substantial amount of residents in Frio County. Our goal is to reduce the readmission rate for patients with heart failure in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare FRH to report outcomes in DY4 and DY5. The two process milestones selected are:

- **P-1:** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
- **P-2:** Establish Baseline Rates
To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Frio County residents.Baseline rates must be established to allow for the measurement of progress in the screening compliance of retinal eye exams.

**Outcome Measure Valuation:**

Heart failure creates a strain of local resources. Unfortunately, many of the associated risk factors for CHF are increasing in our community. Factors such as diabetes, obesity, and hypertension have been on the rise. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Frio County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. With an estimated 13% of patients in Frio County living with diabetes, and that many in pre-diabetic condition, the cost savings and improved quality of life certainly justifies this project.
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<thead>
<tr>
<th><strong>112688002.3.4</strong></th>
<th><strong>3.IT-3.2</strong></th>
<th><strong>Congestive Heart Failure 30 day re-admission rate</strong></th>
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<tbody>
<tr>
<td><strong>PASS 2</strong></td>
<td><strong>Frio Regional Hospital</strong></td>
<td><strong>TPI - 112688002</strong></td>
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<tr>
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<tr>
<td><strong>Starting Point/Baseline:</strong></td>
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<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>P-1 Project Planning</td>
<td>P-2 Establish Baseline Rates</td>
<td>IT-3.2</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Congestive Heart Failure 30 day readmission rate</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $16,221</td>
<td>Process Milestone 2 Estimated Incentive Payment: $20,491</td>
<td>Numerator: The number of readmissions (for patients 18 years and older), for any cause within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission.</td>
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<tr>
<td>Data Source: Electronic Health Record</td>
<td></td>
<td>Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Baseline: TBD in DY 3</td>
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<tr>
<td>Goal: TBD</td>
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<td>Goal: TBD</td>
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<td></td>
<td>Goal: TBD</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $25,677</td>
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<tr>
<td>Year 2 Estimated Outcome Amount:</td>
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<td>Year 3 Estimated Outcome Amount:</td>
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<td>Year 4 Estimated Outcome Amount:</td>
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<td></td>
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<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$27,157</td>
<td></td>
</tr>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $89,546**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Outcome Measures (Improvement Target):</th>
<th>IT – 3.6 Coronary Artery Disease (CAD) 30 day readmission rate</th>
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<tbody>
<tr>
<td>Unique RHP Outcome ID</td>
<td>#112688002.3.5 – PASS 2</td>
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<tr>
<td>Provider Name:</td>
<td>Frio Regional Hospital</td>
</tr>
<tr>
<td>TPI:</td>
<td>112688002</td>
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</tbody>
</table>

### Outcome Measure Description:

This measure focuses on reducing the readmission rate for those patients with a diagnosis of coronary artery disease (CAD). The numerator is the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index of CAD admission. The denominator is the number of admissions (for patients 18 years and older) for patients discharged from the hospital with a principle diagnosis of CAD and with a complete claims history for the 12 months prior to admission. The baseline will be established and outcome numbers for DY4 and DY5 will be determined.

### Rationale:

The measure was selected due to the high incidence of documented coronary artery disease in both Frio County and RHP 6. There are many factors which influence this. Frio County has a 32% adult obesity rate, low access to healthy foods, an elderly population, a 25% uninsured population, a lower per capita income, a high level of diabetes and a high percentage of Hispanics. The above factors all lead to an increased prevalence of CAD. In the RHP itself, CAD is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement in assessing patients with CAD will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access to specialists as well as primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Frio County. Improved access to providers will lead to increased visits and therefore increased screenings. Coronary Artery Disease is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications and readmissions can be prevented with early screening and detection, as well as life style changes. Better assessment of CAD patients can improve the health outcomes of a substantial amount of residents in Frio County. Our goal is to reduce the readmission rate for patients with CAD in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare FRH to report outcomes in DY4 and DY5. The two process milestones selected are:

- P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
- P-2: Establish Baseline Rates
To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Frio County residents. Baseline rates must be established to allow for the measurement of progress in the screening compliance of retinal eye exams.

**Outcome Measure Valuation:**

Coronary artery disease creates a strain of local resources. Unfortunately, many of the associated risk factors for CAD are increasing in our community. Factors such as diabetes, obesity, and hypertension have been on the rise. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Frio County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. With an estimated 13% of patients in Frio County living with diabetes, and that same percentage in pre-diabetic condition, the cost savings and improved quality of life certainly justifies this project.
<table>
<thead>
<tr>
<th>112688002.3.5</th>
<th>3.IT-3.6</th>
<th>Frio Regional Hospital</th>
<th>TPI - 112688002</th>
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<td><strong>Year 2</strong></td>
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<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
</tr>
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<td>P-1 Project Planning</td>
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<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Coronary Artery Disease (CAD) 30 day re-admission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index CAD admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of CAD and with a complete claims history for the 12 months prior to admission.</td>
<td>Improvement Target: Coronary Artery Disease (CAD) 30 day readmission rate. Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index CAD admission. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of CAD and with a complete claims history for the 12 months prior to admission.</td>
</tr>
<tr>
<td>Year</td>
<td>Estimated Outcome Amount</td>
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<td>5</td>
<td>$27,157</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $89,544
Identifying Outcome Measure and Provider Information:

Title of outcome measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) NQF 0059 (standalone measure)
RHP identification number: 138411709.3.1 – PASS 1
Performing Provider: Guadalupe Regional Medical Center
TPI: 138411709

Outcome Measure Description:

Outcome Improvement Target selected for Category 3 is: 1.10 Diabetes Care: HbA1c poor control (>9.0%) under the Outcome Domain: Primary Care and Chronic Disease Management.

Process Milestones will occur in DY2 & DY3.

DY 2 – project planning - will consist of relocating and establishing the clinic in its new setting on the hospital campus, hiring and training staff, and developing a process in conjunction with the hospital’s EMR to accurately track patients with diabetes. We plan to specifically implement these plans through a coordinated team effort by drawing from hospital administrative staff, Christian Free Clinic stakeholders who currently operate the clinic, hospital information technology staff, maintenance staff, and human resource staff to ensure a safe transition occurs between clinic locations. Meetings will be held with these parties to formulate a reasonable relocation timeline, and determine details of clinic operational needs (computers, phones, software etc.), supplies (blood pressure cuffs, otoscopes, etc.). Other details that will be coordinated with the appropriate individuals from this group will include staff screening, hiring and training. Once clinic staff are hired they will be responsible for developing the patient scheduling and tracking mechanism in the EMR system to enable us to accurately track patient information including, lab and imaging results, and view current medications.

DY3 – establish baseline rates - will consist of collaborating with key clinic physicians and the primary physician extender who will be operating the clinic to determine the patient database and determine the patient baseline for improvement. The baseline will be derived from the third year’s patient volume of visits, which we expect to be at least 20 to 30 patient visits a week. This is based on current patient volume from the Christian Free Clinic, which treats 6-10 patients one evening a week.

DYs 4 and 5 will focus on the outcome improvement targets, which will be the health of those patients with poor A1c levels (>9.0%). Specific improvement target goals will be decided in year three once a patient baseline has been determined and health data has been collected on the diabetic patients receiving treatment from the clinic.

Year 2 – Process Milestone 1: P-1 - Project Planning

Milestone 1 - Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.

Data Source: Written planning documentation and /or meeting minutes

Year 3- Process Milestone 2: P-2 Establish baseline rates

Milestone 2: Establish baseline rates by utilizing visit logs and tracking patient volume.

Data Source: Visit Logs / patient activity reports.
Year 4 – Outcome Improvement Target 1: IT – 1.10 Diabetes care: *HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)*

The expected outcome from each of these years is to see a reduction in uncontrolled A1c levels in the patients that are being treated in the clinic. The various methods that will be utilized to achieve this outcome will include: quarterly appointment follow ups with these patients, free A1c lab checks to be interpreted at the patient’s quarterly visit, and personal calls to ensure patients have received their medications, taking them correctly, and are receiving ongoing diabetic education.

**Rationale:**

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half of these cases are undiagnosed. Complications from the disease cost the country approximately $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of healthcare dollars.

The outcome improvement target to control diabetic HbA1c levels was chosen in conjunction with our process improvement measures of expanding primary care access, clinic hours and staffing as a way to make the greatest impact on community need. Due to the high prevalence of uncontrolled diabetic cases in the Seguin community, it was determined that creating a system to identify patients through this newly established clinic with one of the goals being to improve and/or manage patient diabetic A1c levels. Specific target improvement goals will be decided in DY three based on the number of patient visits and data collected on diabetic patients receiving treatment from the clinic.

**Outcome Measure Valuation:**

The scope of this project should be categorized as large, due to the various coordination efforts and data collection processes that will need to be developed to manage and achieve short and long-term goals. The number of diabetic related ER visits and patient admissions is frequent due to the lack of primary care access for those patients who are uninsured, and unable to pay for their diabetic medications. This populations’ education level also presents challenges for long-term success and adds to the complexity of this project, because of their ability to understand the importance of their disease and their need to comply with treatment.

The lack of diabetic resource management in the community is a real issue. By implementing this project and improvement target, we will help reduce the level of chronic disease currently recognized in the community, and hopefully, reduce the future rise of this illness. GRMC is currently receiving no local funding to support the management of this type of project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be decided</td>
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</tbody>
</table>

### Year 2
(10/1/2012 – 9/30/2013)

**Process Milestone 1**
Project Planning – P-1: Engage stakeholders, identify current capacity and needed resources to relocate primary care clinic and expand hours. Determine timelines and document implementation plans.

**Data Source:**
Written planning documentation &/or meeting minutes

**Process Milestone 1 Estimated Incentive Payment:** $132,770

### Year 3
(10/1/2013 – 9/30/2014)

**Process Milestone 2**
P-2: Establish baseline rates

**Data Source:**
Written planning documentation &/or meeting minutes, registry data

**Estimated Incentive Payment:** $76,949

### Year 4
(10/1/2014 – 9/30/2015)

**Outcome Improvement Target 1**
[IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%)
Improvement Target: TBD

**Data Source:** Patient Registry & Administrative Data

**Numerator:** % of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0%

**Denominator:** Patients 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) who attended the clinic

**Outcome Improvement Target 1 Estimated Incentive Payment:** $246,952

### Year 5
(10/1/2015 – 9/30/2016)

**Outcome Improvement Target 2**
[IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%)
Improvement Target: TBD

**Data Source:** Patient Registry & Administrative Data

**Numerator:** % of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0%

**Denominator:** Patients 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) who attended the clinic

**Outcome Improvement Target 2 Estimated Incentive Payment:** $590,537

### Year 2 Estimated Outcome Amount: $132,770

### Year 3 Estimated Outcome Amount: $153,898

### Year 4 Estimated Outcome Amount: $246,952

### Year 5 Estimated Outcome Amount: $590,537

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,124,157
## Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 Day readmission Rate |
| Unique RHP outcome identification number: 138411709.3.2 – PASS 1 |
| Performing Provider: Guadalupe Regional Medical Center |
| TPI: 138411709 |

## Outcome Measure Description:

**The outcome measure for this project is unplanned all-cause 30-day readmissions for patients aged 18 years and older.**

**Year 2 – Process Milestone 1: P-1 - Project Planning**

**Milestone 1** - Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.

**Data Source:** meeting minutes and related policies and procedures, submission of established Policies and procedures of care transitions program materials

**Year 3 - Process Milestone 2: P-2 Establish baseline rates**

**Milestone 2** - Determine baseline for unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group. This milestone measures the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.

**Numerator:** (Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we use this field to define the measure outcome.)

The outcome for this measure is unplanned all-cause 30-day readmission. We defined a readmission as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

**Denominator:** Admissions to acute care facilities for patients aged 65 years or older

**Data Source:** EMR, Claims

**Rationale:** This measure identifies the hospital’s standardized risk ratio (SRR) for readmissions within 30 days of discharge for patients aged 18 years and older; utilizing this baseline data the organization will be able to measure progress toward outcome goals

**Exclusions:**

1. Admissions for patients without 30 days of post-discharge data
   **Rationale:** This is necessary in order to identify the outcome (readmission) in the dataset.

2. Admissions for patients lacking a complete enrollment history for the 12 months prior to admission
   **Rationale:** This is necessary to capture historical data for risk adjustment.

3. Admissions for patients discharged against medical advice (AMA)
   **Rationale:** Hospital had limited opportunity to implement high quality care.

4. Admissions for patients to a PPS-exempt cancer hospital
   **Rationale:** These hospitals care for a unique population of patients that is challenging to compare to other hospitals.

5. Admissions for patients with medical treatment of cancer (See Table 3 in Section 2a1.9)
Rationale: These admissions have a very different mortality and readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions. (Patients with cancer who are admitted for other diagnoses or for surgical treatment of their cancer remain in the measure).

6. Admissions for primary psychiatric disease (see Table 4 in Section 2a1.9)
Rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals.

7. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices”
Rationale: These admissions are not for acute care or to acute care hospitals.

- **Year 4 – Outcome Improvement-IT-3.1 All cause 30 day readmission rate- NQF 1789 (Standalone measure)**
  - Metric: Achieve a 3% reduction from baseline in unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group. % decrease will be determined from baseline is measured in Y2.
    - Numerator: Number of unplanned readmissions within 30 days of discharge for patients 18 years and older
    - Denominator: Total number of admissions for patients 18 years of age and older
    - Data Source: EMR, Claims
    - Rationale: This measure identifies the degree to which the targeted interventions implemented with this project have been successful

- **Year 5 – Outcome Improvement-IT-3.1 All cause 30 day readmission rate- NQF 1789 (Standalone measure)**
  - Metric: Achieve a 5% reduction from baseline in unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group. 5% decrease will be determined after baseline is measured in Y2.
    - Numerator: Number of unplanned readmissions within 30 days of discharge for patients 18 years and older
    - Denominator: Total number of admissions for patients 18 years of age and older
    - Data Source: EMR, Claims
    - Rationale: This measure identifies the degree to which the targeted interventions implemented with this project have been successful

**Rationale:**

Acute care readmissions within 30 days of discharge create an economic and capacity hardship for the healthcare system. The Centers for Medicare and Medicaid Services (CMS) estimates the cost of avoidable readmissions at more than $17 billion each year. Additionally, such readmissions have a negative impact on the quality of life for patients and their families. The ability to coordinate care across the continuum is increasingly recognized as an indicator of the effectiveness of healthcare organizations. Adequately preparing patients for discharge and providing support during the transition process has been shown to contribute significantly to that coordination.

With the aforementioned above, GRMC will monitor EMR, Transitional Care Patient Tracking Logs, and Case Management outcome logs to extrapolate the data. This data will be compiled to document and report the outcome data as it relates to the Transitional Care Program.
**Outcome Measure Valuation:**

Literature has shown that organizations with a high readmission rate for one diagnosis group are likely to have high rates with others as well. GRMC has a CHF readmission rate that is in the fourth (lowest) quartile in the state of Texas for the period of 2006-2007. Our rural service area includes many low income and uninsured/under-insured individuals and families. Significantly reducing readmission rates will improve the quality of life for our community as well as contribute to the continued viability of our organization and opportunities to expand services.
<table>
<thead>
<tr>
<th>PASS 1</th>
<th>3.IT-3.1</th>
<th>All Cause Unplanned 30-day Readmission rate for Patients 18 Years and Older</th>
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<tbody>
<tr>
<td>Guadalupe Regional Medical Center</td>
<td>138411709.2.1</td>
<td>TPI - 138411709</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>P-1- Project planning - engage stakeholders]: Identify current capacity and needed resources, determine timelines and document implementation plan. Data Source: meeting minutes and related policies and procedures, submission of established Policies and procedures of care transitions program materials</td>
<td>P- 2 Establish baseline rates]: Determine baseline for unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group Numerator: All readmissions are counted as outcomes except those that are considered planned. Denominator: Admissions to acute care facilities for patients aged 65 years or older or Data Source: EMR, Claims</td>
<td>IT-3.1: All Cause Unplanned 30-day Readmission rate for Patients 18 Years and Older Metric: Achieve a 3% reduction from baseline in unplanned all-cause readmissions for patients 18 years and older as a percentage of total admissions for same age group. 3% decrease will be determined after baseline is measured in Y2 Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EMR, Claims</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $132,770</td>
<td>Year 3 Estimated Outcome Amount: $153,898</td>
<td>Year 4 Estimated Outcome Amount: $246,952</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,124,158**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization (standalone measure)
RHP Outcome Identification Number: 138411709.3.3 – PASS 2
Performing Provider: Guadalupe Regional Medical Center (GRMC)
Performing Provider TPI #: 138411709

Outcome Measure Description:
The outcome measure that is a part of IT-9.2 that we are choosing to focus on is Reducing Emergency Department visits for target conditions. The condition chosen is Behavioral Health/Substance Abuse. By implementing the Patient Navigation System, GRMC ED would like to decrease the unnecessary ED visits for behavioral health/substance abuse by 3% by year 5.

- **Year 2- Process Milestone 1: P-1 – Project planning**– engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
  - Data source: meeting minutes and related policies and procedures

- **Year 3- Process Milestone 2 P-2: Establish baseline rates**– Identify the amount of unnecessary visits for behavioral health/substance abuse per quarter in the ED
  - Data source: Meditech reports tailored for specific ICD9 codes, nursing documentation, claims
  - Baseline: # of patients identified

- **Year 4- Outcome Improvement Target 1- IT-9.2: ED appropriate utilization** (standalone measure) - Decrease the amount of unnecessary visits for behavioral health/substance abuse in the ED by 1% from baseline determined in Year 3
  - Data source: Meditech reports tailored for specific ICD9 codes, nursing documentation, claims

- **Year 5- Outcome Improvement Target 2- IT-9.2: ED appropriate utilization** (standalone measure)-Decrease the amount of unnecessary visits for behavioral health/substance abuse in the ED by 3% from baseline determined in Year 3
  - Data source: Meditech reports tailored for specific ICD9 codes, nursing documentation, claims

Rationale:
Unnecessary use of the ED is a large financial hardship for the institution, especially for those patients that are uninsured. The milestone was chosen because it seems as if a large number of people are utilizing the ED for unnecessary visits that would be appropriate in a different location such as a doctors’ office or clinic. Behavioral health/substance abuse was chosen as the target condition for the group to focus their efforts in order to steer patients to a behavioral health clinic that uses behavioral health evidence based practices such as: cognitive behavioral therapy, motivational enhancement therapy, motivational interviewing.

Outcome Measure Valuation:
The Navigation Program will assist to manage behavior health/substance abuse patients through outpatient resources, clinics and counseling services outside of the emergency department. Guadalupe County is federally designated as a mental health professional shortage area. An additional report by the Agency for Healthcare Research and Quality, completed in 2010 that mental disorders/substance abuse related visits equal 1 of every 8 emergency department cases. According to a study completed by Salinski and Loftis (2007), Mental health related ER visits increased 75% from 1992 to 2003. MSNBC also reported in 2009, that only 9 patients accounted for 2700 ER visits in a one year period in Austin, Texas. Agency for Healthcare Research and Quality also completed a report in 2010 showing that mental disorders/substance abuse related visits equal 1 of
every 8 emergency department cases. The lack of resources for the mental health patients is not only traumatic for them, but it also takes scarce resources away from the patient with medical emergencies.
<table>
<thead>
<tr>
<th>138411709.3.3 PASS 2</th>
<th>3.IT-9.2</th>
<th>ED Appropriate Utilization (Standalone measure)</th>
</tr>
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<tr>
<td>Guadalupe Regional Medical Center</td>
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<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans&lt;br&gt;Data Source: meeting minutes and related policies and procedures</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-2: Establish baseline rates-identify the amount of unnecessary visits for behavioral health/substance abuse per quarter in the ED&lt;br&gt;Data source: Meditech reports tailored for specific ICD9 codes, nursing documentation, and claims&lt;br&gt;Baseline: # of patients identified</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-9.2: ED appropriate utilization (standalone measure)&lt;br&gt;Improvement Target: Decrease the amount of unnecessary visits for behavioral health/substance abuse in the ED by 1%&lt;br&gt;Data Source: Meditech reports tailored for specific ICD9 codes, nursing documentation, claims</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-9.2: ED appropriate utilization (standalone measure)&lt;br&gt;Improvement Target: Decrease the amount of unnecessary visits for behavioral health/substance abuse in the ED by 3%&lt;br&gt;Data Source: Meditech reports tailored for specific ICD9 codes, nursing documentation, claims</td>
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<td>Process Milestone 1-Estimated Incentive Payment: $ 70,716</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 82,095</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $132,200</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $315,750</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 70,716</td>
<td>Year 3 Estimated Outcome Amount: $ 82,095</td>
<td>Year 4 Estimated Outcome Amount: $ 132,200</td>
<td>Year 5 Estimated Outcome Amount: $ 315,750</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 600,761
### Identifying Outcome Information:

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012)

Unique RHP Outcome Identification Number: 136430906.3.1 – PASS 1

Provider Name: Hill Country Memorial Hospital

TPI: 136430906

### Narrative Description:

**Outcome Measure**

IT-12.2, Cervical Cancer Screening  
- **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.  
- **Denominator:** Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Process Milestones**

- **DY 2:** P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.  
- **DY 3:** P-3 Develop and test data systems

**Outcome Improvements for Each Year**

**DY 4:** IT-12-2, Cervical Cancer Screening (HEDIS 2012)  
- Improvement Target: 40% of all eligible women in the target population of 500 employed uninsured.

**DY 5:** IT-12.2: Cervical Cancer Screening (HEDIS 2012)  
- Improvement Target: 100% of all eligible women in the target population of 500 employed uninsured.

**Starting Point/Baseline (if applicable):**

There currently is no baseline percentage available for the target population since they have not been evaluated for preventive care.

### Rationale:

The process measures for this project include (1) Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans and (2) Develop and test data systems. These steps are key to achievement of the outcome.  
An assessment of parts of the community and businesses with the greatest need will need to be done as well as a plan for ensuring that the key needs for preventive care and wellness are met.  
An outreach strategy as well as a continuity of care detailed strategy will need to be developed at this time. At the moment, a system for collecting client data has not been selected. Options, such as use of systems already in use by the hospital or 501a clinics, may be considered as well as others. For long-term patient and program management, a clear system for managing patient information will be crucial.

The outcome measure of the number of women who have been screened for cervical cancer was chosen because there is currently such limited data available on the health outcomes of the target population. Once we can begin to provide needed preventive care services, we can begin to track the health of the uninsured population in our community with greater accuracy. Though we anticipate that major changes in the health of our community resulting from the program and its continuation past the project period, we do not believe that the screening services we will provide will demonstrate these outcomes in community health data immediately. We will
continue to monitor the health of our community, specifically the uninsured, past the project period, and expect to see a major shift in the overall health of the target population.

The Quality Improvement process for these measures will also include participation in the Learning Collaborative set up in our RHP for those with similar projects. There are a number of others in the RHP focusing their efforts on preventive care, so we look forward to both learning from, and sharing our discoveries with, these other healthcare providers in our region.

<table>
<thead>
<tr>
<th><strong>Outcome Measure Valuation:</strong></th>
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</table>
| This Category 3 outcome measure is valued at $213,203 over the 5 year period. Of the 500 individuals in the target population, one can estimate that about half will be females, at least thirty percent of which will not have had a cervical cancer screening in the last three years. This means, that in addition to the many other health screenings that will be completed on these patients, at least 75 women will be screened for cervical cancer. About 6% will have precancerous results (Risser, Mokry, & Bowcock, et. al., 2010), and will be navigated through appropriate treatment routes. This will prevent, at least $300,000 in costs if those cases had advanced to cervical cancer (Risser, Mokry, & Bowcock, et. al., 2010). Beyond this, it will assist in preventing illness, loss of productivity, and even deaths related to a very preventable disease. Also, the Cancer Prevention Research Institute of Texas found that the uninsured population tends to have a much lower rate of compliance with preventive screening measures (as low as 20%), so it is likely that up to 80% of the women in the target population will require cervical cancer screening. Meeting this need for such a large number in our community will significantly improve the potential for community health. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

“Of all cancers, cervical cancer is one of the most preventable and detectable through regular screening. Yet, cervical cancer remains a serious threat to the lives of Texas women.
- In 2010, an estimated 1,219 Texas women were diagnosed with invasive cervical cancer and 378 women will die of the disease.
- The rates of women being diagnosed with and dying from cervical cancer in Texas are higher than those of the United States overall.
- The estimated direct cost of invasive cervical cancer in Texas for 2007 was $77.4 million.
- Hispanic women have the highest incidence rate of cervical cancer, followed by blacks, non-Hispanic whites, and Asian/Pacific Islanders.
- Blacks have the highest age-adjusted cervical cancer mortality rate, followed by Hispanics, non-Hispanic whites and Asian/Pacific Islanders.
• Hispanic women in the Texas-Mexico border counties have a slightly higher cervical cancer mortality rate than Hispanics in non-border counties.
• Incidence and mortality rates of cervical cancer are higher in rural counties than in urban counties. Overall, the incidence rate of cervical cancer was higher in rural counties (11.6 per 100,000) compared to urban counties (9.5 per 100,000). The overall mortality rate for cervical cancer was higher in rural counties (3.6 per 100,000) compared to urban counties (3.1 per 100,000).
• Eighty percent of women reported having had a Pap test within the past three years. The lowest prevalence of having had a recent Pap test was among women with less than a high school education and women living along the Texas-Mexico border.

As with most cancers, the stage of diagnosis for cervical cancer determines treatment options as well as the prognosis for survival: The earlier the stage in which a tumor is detected, the better the patient’s chance of survival. Relative to the general population, the five-year survival rate among Texas women with localized cervical cancer is almost 90 percent. However, the rate is less than 20 percent for women with distant disease (Figure 1)

From 2003–2007, a total of 5,397 cases of invasive cervical cancer were newly diagnosed in Texas women, with an average of 1,079 cases per year.
• The age-adjusted incidence rate in Texas was 9.7 per 100,000 women. In comparison, the rate from the National Cancer Institute’s Surveillance Epidemiology and End Results (SEER) program was 8.1 per 100,000 (Figure 2). Despite being virtually preventable, cervical cancer killed an average of 340 women in Texas annually from 2002–2006.
• The age-adjusted mortality rate in Texas was 3.1 deaths per 100,000 women compared to 2.5 per 100,000 women in SEER.”

Reference:
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
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<tbody>
<tr>
<td>[P-1]: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>[P-3] Develop and test data systems</td>
<td>[IT-12.2]: Cervical Cancer Screening (HEDIS 2012) Improvement Target: 40% of all eligible women in the target population of 500 employed uninsured. Data Source: Health Record</td>
<td>[IT-12.2]: Cervical Cancer Screening (HEDIS 2012) Improvement Target: 100% of all eligible women in the target population of 500 employed uninsured. Data Source: Health Record</td>
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<tr>
<td>Data Source: Implementation plan documents and timeline</td>
<td>Data Source: Documentation of data management system and functionality</td>
<td>Process Milestone 3 Estimated Incentive Payment: $29,187</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $46,836</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $25,180</td>
<td>Process Milestone 3 Estimated Incentive Payment: $29,187</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $46,836</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $111,999</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $25,180</td>
<td>Year 3 Estimated Outcome Amount: $29,187</td>
<td>Year 4 Estimated Outcome Amount: $46,836</td>
<td>Year 5 Estimated Outcome Amount: $111,999</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $213,202
Identifying Outcome Information:

Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
Unique RHP Outcome Identification Number: 136430906.3.2 – PASS 1
Provider Name: Hill Country Memorial Hospital
TPI: 136430906

Narrative Description:

Outcome Measure
IT-12.3: Colorectal Cancer Screening
   Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years.
   Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Process Milestones
   DY 2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
   DY 3: P-3 Develop and test data systems

Outcome Improvements for Each Year
DY 4: [IT-12-3]: Colorectal Cancer Screening (HEDIS 2012)
   Improvement Target: 40% of all eligible individuals in the target population of 500 employed uninsured.
DY 5: [IT-12-3]: Colorectal Cancer Screening (HEDIS 2012)
   Improvement Target: 100% of all eligible individuals in the target population of 500 employed uninsured.

Starting Point/Baseline (if applicable):
There currently is no baseline percentage available for the target population since they have not been evaluated for preventive care.

Rationale:
The process measures for this project include (1) Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans and (2) Develop and test data systems. These steps are key to achievement of the outcome. An assessment of parts of the community and businesses with the greatest need will need to be done as well as a plan for ensuring that the key needs for preventive care and wellness are met. An outreach strategy as well as a continuity of care detailed strategy will need to be developed at this time. At the moment, a system for collecting client data has not been selected. Options, such as use of systems already in use by the hospital or 501a clinics, may be considered as well as others. For long-term patient and program management, a clear system for managing patient information will be crucial.

The outcome measure of the number of adults who have been screened for colorectal cancer was chosen because there is currently such limited data available on the health outcomes of the target population. Once we can begin to provide needed preventive care services, we can begin to track the health of the uninsured population in our community with greater accuracy. Though we anticipate that major changes in the health of our community resulting from the program and its continuation past the project period, we do not believe that the screening services we will
provide will demonstrate these outcomes in community health data immediately. We will continue to monitor the health of our community, specifically the uninsured, past the project period, and expect to see a major shift in the overall health of the target population.

The Quality Improvement process for these measures will include participation in the Learning Collaborative set up in our RHP for those with similar projects. There are a number of others in the RHP focusing their efforts on preventive care, so we look forward to both learning from, and sharing our discoveries with, these other healthcare providers in our region.

**Outcome Measure Valuation:**

This Category 3 outcome measure is valued at $213,203 over the 5 year period. Of the 500 individuals in the target population, one can estimate that at least 50% will not have been screened for colorectal cancer within the appropriate timeframe. This means, that in addition to the many other health screenings that will be completed on these patients, at least 250 men and women will be screened for colorectal cancer.

Regular cancer screening is extremely important for colorectal cancer. Not only can colorectal cancer screening help detect cancers early, which can improve survival, but it can even prevent cancer from developing by removing noncancerous polyps before they become cancer. It is very important for colorectal cancer to be detected and treated early since stage at diagnosis is the most significant prognostic factor in survival. It is estimated that approximately half of the deaths from colorectal cancer could have been prevented through screening. Preventing just one case of colorectal cancer can save up to $350,000 in costs to the patient and community.

**Reference:**


Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

• Colorectal cancer is the third most commonly diagnosed cancer in men and women and the second leading cause of cancer deaths overall.
• In 2010 it is estimated that 10,366 Texans will be newly diagnosed with invasive colorectal cancer, and 3,578 will die of the disease.
• The estimated total cost of colorectal cancer in Texas for 2007 was almost $3.6 billion.
• Blacks have the highest colorectal cancer incidence and mortality rates, followed by non-Hispanic whites and Hispanics.
• Non-Hispanic whites and Hispanics along the Texas-Mexico border have lower incidence and
mortality rates than non-Hispanic whites and Hispanics in non-border counties.
• There are higher colorectal cancer incidence and mortality rates in rural counties compared to urban counties.
• In Texas, 44.5 percent of adults aged 50 years and older reported having a sigmoidoscopy or colonoscopy in the last five years, and 14.1 percent reported having an annual blood stool test.
• Of the 9,170 average annual cases of colorectal cancer diagnosed among Texans between 2003–2007, 7,338 (80.1 percent) were diagnosed in persons aged 55 years and older.
• More than 50% of the residents of Gillespie County are over the age of 45

Reference:
### Project Description

**136430906.3.2 PASS 1**

#### Related Category 1 or 2 Projects:
- 136430906.2.1

#### Starting Point/Baseline:
- TBD

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<thead>
<tr>
<th>Year</th>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
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<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>[P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>[P-3] Develop and test data systems</td>
<td>Data Source: Implementation plan documents and timeline</td>
<td>Data Source: Health Record</td>
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<td>Data Source: Implementation plan documents and timeline</td>
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<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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**ColoRectal Cancer Screening (HEDIS 2012)**

- **Outcome Improvement Target 1**
  - Improvement Target: 40% of all eligible individuals in the target population of 500 employed uninsured.
  - Data Source: Health Record
  - Outcome Improvement Target 1 Estimated Incentive Payment: $46,836

- **Outcome Improvement Target 2**
  - Improvement Target: 100% of all eligible individuals in the target population of 500 employed uninsured.
  - Data Source: Health Record
  - Outcome Improvement Target 2 Estimated Incentive Payment: $111,999

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $213,204**
**Identifying Outcome Information:**

<table>
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<tr>
<th>Title of Outcome Measure:</th>
<th>IT-12.5 Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older</th>
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<td>Provider Name:</td>
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<td>TPI:</td>
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**Narrative Description:**

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<tbody>
<tr>
<td>IT-12.5: Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Number of adults aged 18 and older that have been screened for high blood pressure (systolic greater than 140, diastolic greater than 90) in the measurement year.</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Number of adults aged 18 and older in the patient or target population.</td>
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</table>

**Process Milestones**

DY 2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

DY 3: P-3 Develop and test data systems

**Outcome Improvements for Each Year**

DY 4: IT-12.5, Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older.

- **Improvement Target:** 40% of all eligible individuals in the target population of 500 employed uninsured.

DY 5: IT-12.5, Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older.

- **Improvement Target:** 100% of all eligible individuals in the target population of 500 employed uninsured.

**Starting Point/Baseline (if applicable):**

There currently is no baseline percentage available for the target population since they have not been evaluated for preventive care.

**Rationale:**

The process measures for this project include (1) Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans and (2) Develop and test data systems. These steps are key to achievement of the outcome. An assessment of parts of the community and businesses with the greatest need will need to be done as well as a plan for ensuring that the key needs for preventive care and wellness are met. An outreach strategy as well as a continuity of care detailed strategy will need to be developed at this time. At the moment, a system for collecting client data has not been selected. Options, such as use of systems already in use by the hospital or 501a clinics, may be considered as well as others. For long-term patient and program management, a clear system for managing patient information will be crucial.

The outcome measure of the number of adults who have been screened for hypertension was chosen because there is currently such limited data available on the health outcomes of the target population. Once we can begin to provide needed preventive care services, we can begin to track the health of the uninsured population in our community with greater accuracy. Though we
anticipate that major changes in the health of our community resulting from the program and its
continuation past the project period, we do not believe that the screening services we will provide
will demonstrate these outcomes in community health data immediately. We will continue to
monitor the health of our community, specifically the uninsured, past the project period, and expect
to see a major shift in the overall health of the target population.

The Quality Improvement process for these measures will include participation in the Learning
Collaborative set up in our RHP for those with similar projects. There are a number of others in the
RHP focusing their efforts on preventive care, so we look forward to both learning from, and
sharing our discoveries with, these other healthcare providers in our region.

**Outcome Measure Valuation:**

This Category 3 outcome measure is valued at $213,203 over the 5 year period. Of the 500
individuals in the target population, one can estimate that at least 95% will not have been screened
for hypertension within the past year. This means, that in addition to the many other health
screenings that will be completed on these patients, at least 475 men and women will be screened
for hypertension. About 32% of Americans are hypertensive (http://www.cdc.gov/nchs/fastats/hyptens.htm) and 31% of those are not aware of it, while 17%
are not being treated. This means that at least 48 individuals will be diagnosed with hypertension
for the first time and almost 80 will be navigated to appropriate care and management of the
disease.

Hypertension is a very prevalent condition that contributes to significant adverse health outcomes,
including premature deaths, heart attacks, renal insufficiency, and stroke. The USPSTF found good
evidence that blood pressure measurement can identify adults at increased risk for cardiovascular
disease due to high blood pressure. “The USPSTF found good evidence that treatment of high
blood pressure in adults substantially decreases the incidence of cardiovascular events. The
USPSTF concludes that there is high certainty that the net benefit of screening for high blood
pressure in adults is substantial. In the United States, hypertension is responsible for 35 percent of
all cardiovascular events (myocardial infarction and stroke), 49 percent of all episodes of heart
failure, and 24 percent of all premature deaths.¹ Patients with hypertension have 2 to 4 times more
risk for stroke, myocardial infarction, heart failure, and peripheral vascular disease than patients
without hypertension.² Additionally, they have an increased risk for end-stage renal disease,
retinopathy, and aortic aneurysm.¹³⁴ This substantial burden of suffering from hypertension, in
combination with a feasible and accurate means of detection and a clear benefit from
treatment,⁵ have led to a widespread recommendation for screening for hypertension.

In 1996, the U.S. Preventive Services Task Force (USPSTF) reviewed the evidence regarding
screening for hypertension.⁵ Based on its review, the USPSTF strongly recommended screening
adults 21 and older using standard office sphygmomanometry. Although they did not recommend a
specific interval for screening, they noted that measurement every 2 years for patients with
previously normal blood pressures and every year in persons with borderline levels may be
prudent.” (http://www.uspreventiveservicestaskforce.org/3rduspstf/highbloodsc/hibloodrev.htm)

One third of all deaths in Gillespie County are related to cardiovascular disease
(http://www.dshs.state.tx.us/hquery/report/?mode=summ&areas=86_255_271).

“Strong indirect evidence supports screening adults for hypertension. Hypertension is an important
contributor to CVD morbidity and mortality. It is predictive of CHD events and is reliably detected
through screening blood pressure measurements using a standard arm blood pressure cuff and
sphygmomanometer. Additionally, treatment of adult hypertensive patients with drug therapy and
possibly nonpharmacological interventions can reduce blood pressure and the incidence of
cardiovascular events, including myocardial infarction, heart failure, and stroke. The degree of risk reduction depends on patients' levels and possibly duration of blood pressure elevation, their other risk factors for CVD, and the choice of antihypertensive treatment. Additionally, despite relatively clear evidence supporting screening and the widespread use of clinical blood pressure measurement, identification and treatment of hypertension remains suboptimal for the U.S. population as a whole. A recent population-based study using National Health and Nutrition Exam Survey (NHANES III) data reported that 31 percent of hypertensive Americans are unaware that they have hypertension, 17 percent are aware of their diagnosis but are not being treated, and 29 percent are being treated but have not controlled their blood pressure. \(^6\) Healthy People 2010 aims to reduce all of these numbers to 5 percent. \(^7\) Substantial progress in organization of care and access to care will be required to approach the Healthy People 2010 goals."

(\url{http://www.uspreventiveservicestaskforce.org/3rdusptf/highbloodsc/hibloodrev.htm})
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 [IT-12.5]: Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older Improvement Target: 40% of all eligible individuals in the target population of 500 employed uninsured. Data Source: Health Record</td>
<td>Outcome Improvement Target 2 [IT-12.5]: Other USPSTF-endorsed screening outcome measures: Screening for high blood pressure in adults aged 18 and older Improvement Target: 100% of all eligible individuals in the target population of 500 employed uninsured. Data Source: Health Record</td>
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<td>Data Source: Implementation plan documents and timeline</td>
<td>Data Source: Documentation of data management system and functionality</td>
<td>Process Milestone 3 Estimated Incentive Payment: $29,188</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $46,836</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $25,181</td>
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<td>Outcome Improvement Target 2 Estimated Incentive Payment: $112,000</td>
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<tr>
<th>Year 2 Estimated Outcome Amount: $25,181</th>
<th>Year 3 Estimated Outcome Amount: $29,188</th>
<th>Year 4 Estimated Outcome Amount: $46,836</th>
<th>Year 5 Estimated Outcome Amount: $112,000</th>
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</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $213,205
Identifying Outcome Measure and Provider Information:

Title of Outcome measure (Improvement Target): 3.IT – 1.12 Diabetes Care: Retinal eye exam
Unique RHP Outcome ID #133260309.3.1 – PASS 1
Performing Provider: Medina Healthcare System (Medina Regional Hospital)
TPI: 212140201

Outcome Measure Description:

Outcome Measure Description:
IT-1.12-Diabetes Care: Retinal Eye Exam

- a) Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:
  - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
  - A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year.

- b) Denominator: Members 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 or type 2).

Process Milestones:

- DY2:
  - P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3:
  - P-2 Establish Baseline Rates

Outcome Improvement Targets for each year:

- DY4:
  - Increase the percent (TBD) of qualified patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.

- DY5:
  - Increase the percent (TBD) of qualified patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.

Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged to affect the outcomes needed. The amount of resources that will be needed must also be identified.

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Medina County residents. Resources needed must be determined and plans implemented to improve the outcomes.
A baseline number of patients who are receiving a retinal or dilated eye exam must be determined to compare improvements made in DY4 and DY5.

Improvement targets:
The measure was selected due to the high incidence of diabetes in both Medina County and RHP 6. Medina County has a 30% adult obesity rate, low access to healthy foods, an elderly population, a 27% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors ALL lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Medina County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as blindness, can be prevented with early screening and detection.

Diabetes screening can improve the health outcomes of a substantial amount of residents in Medina County.

Improvement targets were chosen based on the timeframes of implementation. As eye exams are extremely important in the care of diabetic patients, the outcome measure (IT-1.12) was selected.

Outcome Measure Valuation:

Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Medina County.

The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Medina County living with diabetes, the cost savings (avoidance) and improved quality of life certainly justifies this project.
<table>
<thead>
<tr>
<th>133260309.3.1 PASS 1</th>
<th>3.IT-1.12</th>
<th>Diabetes Care: Retinal Eye Exam</th>
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<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1 Project Planning</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-2 Establish Baseline Rates</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-1.12</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-1.12</td>
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<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a retinal or dilated exam or a negative exam in the prior year. Goal: TBD Data Source: Electronic Health Record</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a retinal or dilated exam or a negative exam. Goal: TBD Data Source: Electronic Health Record</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $21,733</td>
<td>Process Milestone 2 Estimated Incentive Payment: $25,192</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $40,424</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $96,666</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $21,733</td>
<td>Year 3 Estimated Outcome Amount: $25,192</td>
<td>Year 4 Estimated Outcome Amount: $40,424</td>
<td>Year 5 Estimated Outcome Amount: $96,666</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $184,015**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): 3.IT – 1.13 Diabetes Care: Foot Exam
Unique RHP Outcome ID # 133260309.3.2 – PASS 1
Performing Provider: Medina Healthcare System (Medina Regional Hospital)
TPI: 212140201

Outcome Measure Description:

IT-1.13 Diabetes Care

- a) Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.
- b) Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Process Milestones:

- DY2:
  - P-1 Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3:
  - P-2 Establish Baseline Rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.13: Increase the percent (TBD) of qualified patients who receive a foot exam.
- DY5:
  - IT-1.13: Increase the percent (TBD) of qualified patients who receive a foot exam.

Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged to affect the outcomes needed.

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Medina County residents.

A baseline number of diabetic patients receiving a foot exam must be determined to assess what is currently being accomplished. Improvements will be made from the baseline percent.

Improvement targets:
The measure was selected due to the high incidence of diabetes in both Medina County and RHP 6. Medina County has a 30% adult obesity rate, low access to healthy foods, an elderly population, a 27% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors ALL lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.
Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Medina County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as amputations, can be prevented with early screening and detection. Diabetes screening can improve the health outcomes of a substantial amount of residents in Medina County.

Our goal is increased foot exams in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare MRH to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

P-2: Establish Baseline Rates

**Outcome Measure Valuation:**

Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Medina County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Medina County living with diabetes, the cost savings (avoidance) and improved quality of life certainly justifies this project.
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<tr>
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<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
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<tr>
<td>P-1 Project Planning</td>
<td>P-2 Establish Baseline Rates</td>
<td>IT 1.13</td>
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<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Increase the percent of qualified patients who receive a foot exam. Data Source: Electronic Health Record Goal: TBD</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $21,733</td>
<td>Process Milestone 2 Estimated Incentive Payment: $25,192</td>
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<td>Year 5 Estimated Outcome Amount: $96,665</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $184,014
## Identifying Outcome Measure and Provider Information:

**Title of Outcome Measure (Improvement Target):** 3.IT – 1.14 Diabetes Care: Microalbumin/Nephropathy  
**Unique RHP Outcome ID #:** 133260309.3.3 – PASS 1  
**Performing Provider:** Medina Healthcare System (Medina Regional Hospital)  
**TPI:** 212140201

## Outcome Measure Description:

**IT-1.14-Diabetes Care: Microalbumin/Nephropathy**

- **a)** Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
- **b)** Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

This measure includes diabetic patients who had a nephropathy screening test or evidence of nephropathy. The denominator is the number of patients 18-75 years old who have evidence of nephropathy or a nephropathy screening. The baseline will be established and outcome numbers for DY4 and DY5 will be determined.

### Process Milestones:

- **DY2:**
  - P-1 Project Planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- **DY3:**
  - P-2 Establish Baseline Rates

### Outcome Improvement Targets for each year:

- **DY4:**
  - Increase the percent (TBD) of qualified patients who had a nephropathy screening test or evidence of nephropathy.
- **DY5:**
  - Increase the percent (TBD) of qualified patients who had a nephropathy screening test or evidence of nephropathy.

### Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged to affect the outcomes needed. The amount of resources that will be needed must also be identified. A baseline number of patients who currently qualify and are receiving a nephropathy screening test must be determined to compare improvements made in DY4 and DY5.

To effect change in both provider adherence to protocols and patient compliance, this project must be planned and organized with all stakeholders on board. These stakeholders include physicians, mid-level providers, staff, management, administration, and Medina County residents. Baseline rates must be established to allow for the measurement of progress in the number nephropathy screening tests.
Improvement targets:
The measure was selected due to the high incidence of diabetes in both Medina County and RHP 6. Medina County has a 30% adult obesity rate, low access to healthy foods, an elderly population, a 27% uninsured population, a lower per capita income and a high percentage of Hispanics. The above factors ALL lead to an increased prevalence of diabetes. In the RHP itself, diabetes is one of the leading causes of death. Disease management and screening are paramount to improving health outcomes in this population.

Addressing quality care and improvement of screening exams in the diabetic population will also lead to an improvement in potentially preventable admissions. (Between 2005 and 2010 HHSC found that RHP 6 had over 125,000 potentially preventable hospitalizations.)

The ability to access primary care clinics and providers, i.e. ease of availability, is key in reaching patients in Medina County. Improved access to providers will lead to increased visits and therefore increased screenings. Diabetes is both prevalent and costly, with many patients going undiagnosed. Complications lead to increased emergency room utilization and increased costs overall. Many of those complications such as kidney failure, can be prevented with early screening and detection.

Diabetes screening can improve the health outcomes of a substantial amount of residents in Medina County. Our goal is increased nephropathy screening tests in DSRIP year 4 (DY4) and in DY5 over the baseline established. After establishing the baseline rates, outcome improvement targets will be determined.

**Outcome Measure Valuation:**
Diabetes is a terribly expensive disease. A recent study from the CDC predicts a dramatic increase in diabetes between now and 2050. The Institute for Alternative Futures estimates that the number of Texans with diabetes will increase by 66% by 2025. The resulting medical and societal cost will be over $51 billion – a 78% increase from 2010. Diabetes can lead to heart failure, blindness, heart attack, kidney failure and amputations. From the Texas Diabetes Council, Medicaid reimbursement for diabetes related services (2006) reached $443 million. In 2010, 373,000 Texans were visually impaired due to diabetes; 5,570 had renal failure, and 7,840 lower extremity amputations. From the “Institute of Alternative Futures”, the total cost of diabetes care in Texas was $28.8 billion in 2010. Treating and preventive screening could drastically reduce this number (cost-avoidance) both in Texas, RHP 6, and in Medina County. The rural health clinics reported over 47,000 visits in FY 2012, and if 13% of the patients had diabetes as a diagnosis, early screening could prevent numerous complications, hospitalization, and emergency department utilization. From the American Diabetes Association, “people with diabetes incur $6,649 annually attributable to diabetes”. $1 in $5 of healthcare dollars in the United States is spent caring for someone with diabetes. If 50% of diabetic patients received high quality medical care in a primary care setting and complied with physician orders, the number of lower extremity amputations could be reduced by over 2,220/year and 31,000 fewer people could develop end-stage renal disease. With an estimated 13% of patients in Medina County living with diabetes, the cost savings (avoidance) and improved quality of life certainly justifies this project.
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<thead>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> P-1 Project Planning</td>
<td><strong>Process Milestone 2</strong> P-2 Establish Baseline Rates</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $21,733</td>
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<td><strong>Year 2 Estimated Outcome Amount: $21,733</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $25,191</strong></td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $184,012**
Identifying Outcome Measure and Provider Information:

Title of Outcome measure (Improvement Target): IT-12.1 Breast Cancer Screening
Unique RHP Outcome ID #133260309.3.4 – PASS 2
Performing Provider: Medina Healthcare System (Medina Regional Hospital)
TPI: 212140201

Outcome Measure Description:

IT-12.1 Breast Cancer Screening

- **Numerator:** Number of women aged 40-69 that have received an annual mammogram during the reporting period.
- **Denominator:** Number of women aged 40-69 in the patient or target population (women who have had a bilateral mastectomy are excluded).

Process Milestones:

- **DY2:**
  - P-1 Project Planning-Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

- **DY3:**
  - P-2 Establish Baseline Rates

Outcome Improvement Targets for each year:

IT-12.1

- **DY4:**
  - Increase the number of women aged 40-69 that receive an annual mammogram during the reporting period. The goal is (TBD) % increase in DY4 over baseline.

- **DY5:**
  - Increase the number of women aged 40-69 that receive an annual mammogram. The goal is (TBD) % improvement over baseline.

Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged for the successful outcomes of this project. Needed resources, including people and technology, must be determined to manage the process. Plans certainly must be discussed, agreed upon, and implemented. To measure improvement, baseline data must first be determined. Medina Regional Hospital will work with the medical staff, mid-levels and clinic personnel to increase the number of patients who receive mammograms.

Improvement targets:

This is a relevant outcome measure for Category 1, Project: Enhancing Performance Improvement and Reporting Capacity. By educating and equipping staff with a variety of improvement tools, the healthcare team can identify ways to increase the number of females completing mammograms. The objective of the screening is to reduce the incidence of and death from cancer by early detection.
Outcome Measure Valuation:

Medina Regional Hospital values each project based on community needs, the projected health outcomes, relationship to RHP, and resources needed to affect the outcomes.

According to the “Agency for Healthcare Research and Quality’s 2011 report”, Texas scored WEAK on preventive measures and average on cancer measures. Cancer is one of the leading causes of death in RHP6. Of the 16,000 deaths in 2008, 60% were due to potentially preventable causes. Screenings and preventive measures to reducing mortality and morbidity are critical.

Breast cancer is the second leading cause of death from cancer in American women. According to the National Cancer Institute, screening mammography can help reduce the number of deaths from breast cancer among women ages 40 to 70; getting a high quality screening mammogram on a regular basis is one of the most effective ways to detect breast cancer early.

According to a recent cancer study, early detection and advances in technology (for women in Wisconsin), resulted in death rates plunging by 20% for breast cancer.

The estimated per lifetime/per patient cost of breast cancer range from $23,000-$31,000 (The cost of treating breast cancer in the US; a synthesis of published evidence-Pharmacoeconomics, 2009). As in all preventive measures, early detection is key in treatments and is cost savings. Multiple studies have confirmed that costs increased with increased stage of the disease.

This outcome measure is justified by a decreased mortality in the community affecting a larger percent of the female population, a possible decrease in hospitalizations and a decrease in costs with early detection (cost-avoidance).
### Related Category 1 or 2 Projects:
133260309.1.2

### Starting Point/Baseline:

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<tr>
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<th>Year 4</th>
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#### Process Milestone 1
P-1 Project Planning - Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

- **Data Source:** Planning Document
- **Process Milestone 1 Estimated Incentive Payment:** $5,787

#### Process Milestone 2
P-2 Establish Baseline Rates -

- **Data Source:** Electronic Health Record
- **Process Milestone 2 Estimated Incentive Payment:** $6,719

#### Outcome Improvement

**Target 1**

- **IT-12.1**
- **Improvement Target:** Increase the number of women aged 40 to 69 that have received an annual mammogram during the reporting period. (Women who have had a bilateral mastectomy are excluded.)
- **Goal:** (TBD) % increase over DY3 baseline.
- **Data Source:** Electronic Health Record
- **Outcome Improvement Target 1 Estimated Incentive Payment:** $10,820

**Target 2**

- **IT-12.1**
- **Improvement Target:** Increase the number of women aged 40 to 69 that have received an annual mammogram during the reporting period. (Women who have had a bilateral mastectomy are excluded.)
- **Goal:** (TBD) % over DY3 baseline.
- **Data Source:** Electronic Health Record
- **Outcome Improvement Target 2 Estimated Incentive Payment:** $25,842

#### Estimated Outcome Amounts:

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<td>Estimated Outcome Amount: $10,820</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $49,168**
Identifying Outcome Measure and Provider Information:

| Title of Outcome measure (Improvement Target): | IT-12.2 Cervical Cancer Screening |
| Unique RHP Outcome ID # | 133260309.3.5 – PASS 2 |
| Performing Provider: | Medina Healthcare System (Medina Regional Hospital) |
| TPI: | 212140201 |

Outcome Measure Description:

| Outcome Measure Description: |
| IT-12.2 Cervical Cancer Screening |
| - Numerator: Number of women aged 21-64 that have received a PAP in the measurement year or two prior years. |
| - Denominator: Women aged 21-64 in the patient or target population (women who have had a complete hysterectomy with no residual cervix are excluded). |

Process Milestones:

- DY2:
  - P-1 Project Planning-Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3:
  - P-2 Establish Baseline Rates

Outcome Improvement Targets for each year:

| IT-12.2 |
| - DY4:
  - Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two years prior. The goal is (TBD) % increase in DY4 over baseline. |
| - DY5:
  - Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two years prior. The goal is (TBD) % increase over baseline. |

Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged for the successful outcomes of this project. Needed resources, including people and technology, must be determined to manage the process. Plans certainly must be discussed, agreed upon, and implemented. To measure improvement, baseline data must first be determined. Medina Regional Hospital will work with the medical staff, mid-levels and clinic personnel to increase the number of PAPs.

Improvement targets:

This improvement target was selected for a number of reasons. This is a relevant outcome measure for Category 1, Project 1.10, Enhance Performance Improvement Capacity and Reporting. By educating and equipping both staff and physicians with a variety of process
improvement tools, the healthcare team can identify and improve the number of PAP exams. Reporting can be more precise with closer and more rigorous follow-through.

This outcome target is important, as cancer is one of the leading causes of death in RHP6. Cancer screening tests are effective when they can detect disease early. The incidence of PAPs will be increased by (TBD) % in DY4 and (TBD) % over baseline in DY5.

**Outcome Measure Valuation:**

Medina Regional Hospital values each project based on community needs, relation to RHP6, and resources needed to affect the outcome.

This project serves women at Medina Regional Hospital who are 21-64 years of age. Detecting disease early can lead to more effective treatment. Of all the gynecologic cancers, only cervical cancer has a screening exam – the PAP test. This test also helps prevent cervical cancer by finding pre-cancers. Dysplasia, a pre-cancerous condition, detected by PAP test, is 100% treatable.

Worldwide, cervical cancer is the third most common type of cancer in women. Early cervical cancer can be cured. Pap smears effectively spot changes, but they must be done regularly (A.D.A.A. Medical Encyclopedia). According to the National Cancer Institute, the estimated new cases of cervical cancer (2012) is 12,170; 4,220 deaths. As reported in “Women’s Health Issues” (2010), total Medicaid costs at 6 months after diagnosis were $3,807, $23,187, $35,853, and $45,028 for in situ, local, regional, and distant cancers respectively.

It was concluded that given the great differences in cost of early vs. late-stage cancers, interventions aimed at increasing screening among low-income women are likely to be cost effective (cost-avoidance).
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133260309.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
</tr>
<tr>
<td>P-1 Project Planning-Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>P-2 Establish Baseline Rates-Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Process Milestone 2 Estimated Incentive Payment: $6,719</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $5,787</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2:</strong></td>
<td><strong>Outcome Improvement Target 2:</strong></td>
</tr>
<tr>
<td>IT-12.2 Improvement Target: Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. (Women who have had a complete hysterectomy with no residual cervix are excluded.)</td>
<td>IT-12.2 Improvement Target: Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. (Women who have had a complete hysterectomy with no residual cervix are excluded.)</td>
</tr>
<tr>
<td>Goal: Increase by (TBD) % over DY3. Data Source: Electronic Health Record</td>
<td>Goal: Increase by (TBD) % over DY3. Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $25,842</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $5,788</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $6,719</strong></td>
</tr>
</tbody>
</table>
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $49,170
### Identifying Outcome Measure and Provider Information:

| Title of Outcome measure (Improvement Target): | IT-12.4 Pneumonia vaccination status for older adults. |
| Unique RHP Outcome ID #133260309.3.6 – PASS 2 | Performing Provider: Medina Healthcare System (Medina Regional Hospital) |
| TPI: 212140201 | |

### Outcome Measure Description:

**IT-12.4 Pneumonia vaccination status for older adults**

- Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine.
- Denominator: Number of adults aged 64 and older in the patient or target population.

### Process Milestones:

- **DY2:**
  - P-1 Project Planning-Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- **DY3:**
  - P-2 Establish Baseline Rates

### Outcome Improvement Targets for each year:

**IT-12.4**

- **DY4:**
  - Increase the number of adults aged 65 and older that have ever received a pneumonia vaccine. Increase by (TBD) % over DY3 baseline.

- **DY5:**
  - Increase the number of adults aged 65 and older that have ever received a pneumonia vaccine. Increase by (TBD) % over baseline.

### Rationale:

Process milestones – P-1 through P-2 were chosen because stakeholders must be identified and engaged for the successful outcomes of this project. Needed resources, including people and technology, must be determined to manage the process. Plans certainly must be discussed, agreed upon, and implemented. To measure improvement, baseline data must first be determined. Medina Regional Hospital will work with the medical staff, mid-levels and clinic personnel to increase the number of pneumonia vaccinations.

**Improvement targets:**

This improvement target was selected for numerous reasons: lack of access to primary care in RHP6, 12% of the residents are over age 65, and a low per capita income, adding barriers to preventive care. Under the category of “Type of Care” (according to the Agency for Healthcare Research and Quality’s 2011 report), Texas scored WEAK on preventive measures. Between 2005-2110, The Texas HHS commission found that RHP 6 had 125,090 potentially preventable hospitalizations. If individuals had access to preventive care, many of these could be avoided. Thus, these improvement targets were selected to increase the amount of older adults receiving the...
pneumonia vaccine. Our goal in DY4 and DY5 is to improve access to care, and increase these vaccines, utilizing a formal process improvement model developed (1.10).

This is a relevant outcome measure for Category 1, Project: Enhance Performance Improvement. By educating and equipping staff with a variety of process improvement tools, the healthcare team can identify ways to increase the number of vaccines given.

**Outcome Measure Valuation:**

Older adults are especially vulnerable to certain diseases such as influenza and pneumonia. In 2008, the CDC reported that adults aged 65 and older comprised 90% of the deaths that occur every year from complications related to these. Vaccinations help older adults protect themselves from getting pneumonia and other illnesses. According to the National Institute of Health, October 15, 2012, pneumococcal pneumonia can be contagious and is responsible for as many as 302,000 hospitalizations in the U.S. every year. In 2009, pneumonia ranked 8th among the 15 leading causes of death in the U.S.

As reported in “Respiratory Reviews” (Vol. 5, #5), pneumococcal vaccination of high risk groups, especially elderly, leads to a substantial reduction in mortality. This report states that the vaccination was associated with a 43% reduction in hospitalizations for pneumonia, a 29% reduction in mortality, and a cost savings of $113-$512/person vaccinated.

This outcome measure is justified by decreased mortality in the community affecting a large percentage of the population; a decrease in hospitalizations (cost avoidance); and a decrease in the spread of pneumonia. This is obviously a community need for Medina County as well as RHP6.
### Medina Healthcare System (Medina Regional Hospital) TPI - 212140201

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133260309.1.2</th>
</tr>
</thead>
</table>

#### Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Process Milestone 1
- **P-1 Project Planning**: Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
  - Data Source: Planning Document
  - Process Milestone 1 Estimated Incentive Payment: $5,787

#### Process Milestone 2
- **P-2 Establish Baseline Rates-Data Source**: Electronic Health Record
  - Process Milestone 2 Estimated Incentive Payment: $6,719

#### Outcome Improvement Target 1
- **IT-12.4 Improvement Target**: Increase the number of adults aged 65 and older that have ever received a pneumonia vaccine.
  - Goal: Increase by (TBD) % over DY3.
  - Data Source: Electronic Health Record
  - Outcome Improvement Target 1 Estimated Incentive Payment: $10,820

#### Outcome Improvement Target 2
- **IT-12.4 Improvement Target**: Increase the number of adults aged 65 and older that have ever received a pneumonia vaccine.
  - Goal: Increase by (TBD) % over DY3.
  - Data Source: Electronic Health Record
  - Outcome Improvement Target 2 Estimated Incentive Payment: $25,842

#### Year 2 Estimated Outcome Amount: $5,788
#### Year 3 Estimated Outcome Amount: $6,719
#### Year 4 Estimated Outcome Amount: $10,820
#### Year 5 Estimated Outcome Amount: $25,843

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $49,170**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-6.1 Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome ID:</td>
<td>094154402.3.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider Name:</td>
<td>Methodist Hospital</td>
</tr>
<tr>
<td>TPI:</td>
<td>094154402</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**Title of Outcome Measure**: IT-6.1 Percent improvement over baseline of patient satisfaction scores

**Process Milestones**:

- **DY2**:
  - P-1 – Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance
  - P-4 - Integrate patient experience into employee training

- **DY3**:
  - P-7 – Assess the organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement

**Outcome Improvement Targets for each year**:

- **DY4**:
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores on their rating of doctor access to specialist of 2% over baseline.

- **DY5**:
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores on their rating of doctor access to specialist of 4% over baseline.

Methodist Healthcare System will measure if the patient’s access to care was improved over baseline visits. The baseline will be determined in DY3. Subsequent years will attempt to improve access to care by end of waiver.
### Rationale:

Process Milestones P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor Telemedicine. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baseline to determine if access to care has improved using Telemedicine. The improvement measure will be determined by patient access before Telemedicine was implemented.

Currently, patients receive a specialist consult via telephone with the attending physician in another facility. We feel that we can significantly increase the quality of care by having a specialist see and communicate with the patient in order to best assess their ability for local care or the need to start therapy and transport to a regional facility.

This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

### Outcome Measure Valuation:

Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which a telemedicine program would potentially meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
<table>
<thead>
<tr>
<th>094154402.3.1 PASS 1</th>
<th>3.IT-6.1</th>
<th>IT-6.1 Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Hospital</td>
<td></td>
<td>TPI - 094154402.1.1</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>094154402.1.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be implemented in DY3</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2] Establish baseline. Data Source: Registry, EHR, claims or other Performing Provider source</td>
<td>Outcome Improvement Target 1 IT-6.1: Percent improvement over baseline of patient satisfaction scores on their rating of doctor access to specialist of 2% over baseline. Metric (3): Patient’s rating of doctor access to specialist  a. Numerator: Percent improvement in targeted patient satisfaction domain.  b. Data Source: Patient Survey  c. Denominator: Number of patients who were administered the survey.  d. Rationale/Evidence: The intent of this initiative is to provide a standardized survey instrument and data collection methodology for measuring patient’s perspectives on their</td>
</tr>
<tr>
<td>Data Source: Assessments and program data Process Milestone 1: Estimated Incentive Payment: $284,324</td>
<td>Process Milestone 4 Estimated Incentive Payment: $329,569</td>
<td>Outcome Improvement Target 2 IT-6.1: Percent improvement over baseline of patient satisfaction scores on their rating of doctor access to specialist of 4% over baseline. Metric (3): Patient’s rating of doctor access to specialist  a. Numerator: Percent improvement in targeted patient satisfaction domain.  b. Data Source: Patient Survey  c. Denominator: Number of patients who were administered the survey.  d. Rationale/Evidence: The intent of this initiative is to provide a standardized survey instrument and data collection methodology for measuring patient’s perspectives on their</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $284,324</td>
<td>Year 3 Estimated Outcome Amount: $329,569</td>
<td>Year 4 Estimated Outcome Amount: $528,843</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,407,360</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction |
| Unique RHP outcome ID: 094154402.3.2 – PASS 1 |
| Performing Provider Name: Methodist Hospital |
| TPI: 094154402 |

**Outcome Measure Description:**

To improve how the patient experiences the care and the patient's satisfaction with the care provided by ultimately exceeding the patient’s expectations for customer service by utilizing the HCAPS ED Loyalty Composite score. Emergency room baseline will be determined in DY 3 with 4% improvement by DY5.

**Rationale:**

Positive outcomes in healthcare are dependent not only upon the clinical success of treatment, but also upon the patient's perception of the overall experience, which improves compliance and understanding. This experience is comprised, in part, of communication with the caregivers regarding different aspects of the process, as well as the level of service with respect to clean/quiet environment for healing and a responsive staff aimed at meeting needs in a timely manner. In order to better partner with our patients to round out this overall experience, focus upon patient satisfaction metrics and methods to achieve improvement thereof is necessary. We utilize the Gallup survey tools, as well as other internal, more real-time solutions in order to obtain feedback regarding all aspects of the patient experience.

This process milestone was chosen to improve how the patient experiences the care and the patient’s satisfaction with the care provided. The overall approach to redesigning the patient experience will be to improve patient experience scores over baseline. The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Outcome Measure Valuation:**

We will measure our emergency room patients that receive service at this freestanding emergency room, according to the inclusion criteria that a national polling organization uses for emergency room services. This survey will include a sampling of patients that receive services at this center. The community benefits by us gaining more real-time feedback (available immediately after patient contact made) in order to improve processes and procedures for the good of the care experience. The project seeks to provide increased emergency room visits in an area of community need by 2,053 visits in DY 3, 4,721 visits in DY 4, and 5,132 visits in DY5.
<table>
<thead>
<tr>
<th>094154402.3.2 PASS 1</th>
<th>3.IT-6.1 Patient Satisfaction</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>METHODOIST HOSPITAL</strong></td>
<td>094154402.1.2</td>
<td>TP1 - 094154402</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>To be determined in DY3.</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2</strong> [P-3]: Develop and test data systems</td>
<td><strong>Process Milestone 3</strong> [P-2] Establish baseline rates.</td>
</tr>
<tr>
<td>Data Source: Assessment Process Milestone 1 Estimated Incentive Payment: $142,162</td>
<td>[Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data.]</td>
<td>[Orchestrate improvement work on identified experience targets and determine baseline.]</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-6.2]: Utilize Hospital Patient Satisfaction survey tools which combines HCAHPS questions with unique measures</td>
<td>Improvement Target: Baseline will be to determine number of patient satisfaction surveys and attain percentage in the top 50th percentile of patient satisfaction scores.</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $528,843</td>
</tr>
<tr>
<td>Data Source: Patient Survey</td>
<td>Data Source: Implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: Patient Survey</td>
<td>Outcome Improvement Target 1</td>
<td></td>
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</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $142,162</td>
<td>Estimated Incentive Payment: $164,784</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $284,324 | Year 3 Estimated Outcome Amount: $329,569 | Year 4 Estimated Outcome Amount: $528,843 | Year 5 Estimated Outcome Amount: $1,264,624 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,407,360**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification number: 094154402.3.3 – PASS 1
Performing Provider: Methodist Hospital
TPI: 094154402

Outcome Measure Description:
To improve how the patient experiences the care and the patient's satisfaction with the care provided by ultimately improving the Customer Engagement (CE1) score of “Overall Satisfaction” with Inpatient Services score by 4%, as measured by patient survey. This will be accomplished by improving 1-2% each year within the project timeframe. We will measure our inpatient adult and pediatric patients discharged from Methodist Hospital, according to the inclusion criteria the patient survey vendor uses nation-wide. This includes approximately 1,600 patient interviews per quarter across all service lines and all six campuses. The community benefits by us gaining more real-time feedback (available immediately after patient contact made) in order to improve processes and procedures for the good of the care experience.

MHS Customer Engagement survey differs from the HCAHPS survey tool utilized by CMS in a variety of different manners: One, it is a much broader measurement tool. The CE1 includes measurements of patient experiences Inpatient, Outpatient Surgery, Emergency and Test and Treatment areas of the healthcare environment. Two, it asks a much larger variety of questions regarding the experience, which ultimately culminate in the “overall satisfaction” question. And three, the composite values are weighted according to the overall impact each area of the patient volume has on the overall facility flow.

Rationale:
Patient experience is directly correlated with quality of care and thus, the overall health of a community. For example, positive outcomes in healthcare are dependent not only upon the clinical success of treatment, but also upon a patient's perception of the overall experience, which improves compliance and understanding. This experience is comprised, in part, of communication with the caregivers regarding different aspects of the process, as well as the level of service with respect to clean/quiet environment for healing and a responsive staff aimed at meeting needs in a timely manner. In order to better partner with our patients to round out this overall experience, focus upon patient satisfaction metrics and methods to achieve improvement thereof is necessary. We utilize the patient survey tools, as well as other internal, more real-time solutions in order to obtain feedback regarding all aspects of the patient experience.

Methodist chose a process milestone to develop and test data systems and establish a baseline because these two processes are logistically essential to the completion of the project. Additionally, Methodist chose the target percentage for the selected ITs at 2% and 4%, because while customer engagement is very important, it is often difficult to predict. Therefore, Methodist feels that even a small increase in customer engagement is beneficial and worthwhile to pursue.

Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.
<table>
<thead>
<tr>
<th><strong>Outcome Measure Valuation:</strong></th>
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</thead>
<tbody>
<tr>
<td>In determining the value of this project, Methodist analyzed the needs of the community, the number of patients reached by the project, the value of the anticipated benefit to health outcomes in the community, the time, the effort, and clinical expertise involved in implementing the project, the clinical resources required to perform the project, and the anticipated value of the improvement of delivery of care to the community.</td>
</tr>
<tr>
<td>PROCESS MILESTONE 1</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>[ P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
</tr>
<tr>
<td>Data Source: Assessment</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $142,162</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $284,324</td>
<td>Year 3 Estimated Outcome Amount: $329,569</td>
<td>Year 4 Estimated Outcome Amount: $528,843</td>
<td>Year 5 Estimated Outcome Amount: $1,264,624</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,407,360**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-4.8  Sepsis mortality |
| Unique RHP ID: | 094154402.3.4 – PASS 1 |
| Performing Provider Name: | Methodist Hospital |
| TPI: | 094154402 |

### Outcome Measure Description:

Outcome measure will be Number of patients expiring during current month with sepsis / Number of patients identified that month with sepsis. Goal is to improve mortality rates to at or below expected rates (observed/expected mortality ratio to 1.0 or lower) by the end of the waiver. The process milestones to achieve this will be development of an Early Sepsis Recognition form to be used in the ED and in-hospital for patients suspected of sepsis. This will be completed by nursing staff in the ED as well as floor nurses as part of the Rapid Response Team. We will also develop evidence-based order sets for Rapid Sepsis Resuscitation for initial therapy and Sepsis Maintenance Protocol order sets for on-going hospital care. Compliance with these data forms and order sets will help in early recognition, early aggressive resuscitation and appropriate on-going care with evidenced-based protocols. This has been proven to reduce sepsis mortality.

### Rationale:

Implement an innovative and evidence based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.

Rationale for selecting this sepsis project is the high mortality rate in this population and the known evidenced-based care bundles for decreasing mortality in this population. In CY 2010, MH served 2046 patients with a primary diagnosis of sepsis in DRG 870 and 871. In DRG 870 (Severe Sepsis with Mechanical Ventilation > 96 hours), there were 209 patients with a mortality rate of 32.2% and an expected rate of 30.47%. In DRG 871 (Severe Sepsis without Mechanical Ventilation) there were 1837 patients with a mortality rate of 16.05% and an expected rate of 18.37%. The observed/expected mortality rate for DRG 870 is 1.06 (6% above expected) and for DRG 871 observed/expected mortality is 0.87 (13% below expected).

The goal for the 5 year project is a mortality rate at or below expected for a select group of sepsis patients identified at baseline DY3.

The improvement requires significant planning, development of metrics, tools and education of all stakeholders. This is expected to be a 5 year process. This addresses Category 2.8.11, Applying Process Improvement methodology to Improve Quality/Efficiency. This project is timely for our Hospital and has been identified as a key element in our Clinical Efficiency (CE) hospital plan. Outcome improvement targets will be determined in DY2 for implementation in DY3.

### Outcome Measure Valuation:

In valuing this project, Methodist took into account the extent to which the Improvement in Sepsis would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The Improvement in Sepsis Mortality will save lives of citizens in the community. This directly
addresses the goals by implementing proven evidenced-based clinical methodology to improve care in this devastating illness. Methodist took these factors into account when determine the incentive value of this project.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>[P-2] Establish baseline rates</td>
<td>Improvement Target: at or below expected mortality or 2% reduction from baseline if mortality rate is &gt; 2% of expected. (observed / expected mortality ratio of 1.02).</td>
<td>Improvement Target: at or below expected mortality rates (observed/expected mortality of 1.0 or lower) for sepsis population defined in DY3 baseline.</td>
</tr>
<tr>
<td>Development of an Early Sepsis Recognition form to be used in the ED and in-hospital for patients suspected of sepsis. This will be completed by nursing staff in the ED as well as floor nurses as part of the Rapid Response Team. This form will be placed in the Hospital Clinical Information System.</td>
<td>Measurement is number of Sepsis patients expiring/ number of Sepsis patients</td>
<td>Data Source: Performing Provider data</td>
<td>Data Source: Performing Provider data</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $329,569</td>
<td>Data Source: Hospital Clinical Information System.</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $528,843</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,264,624</td>
</tr>
</tbody>
</table>
[P-3]: Develop and test data systems

- Development of Rapid Sepsis Resuscitation protocols for initial management and Sepsis Maintenance Protocol for continuum of care. These are entered into the information system as part of evidenced-based care orders.

- Data Source: Hospital Clinical Information System.

- Process Milestone 2 Estimated Incentive Payment: $142,162

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $284,324</th>
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<th>Year 4 Estimated Outcome Amount$528,843</th>
<th>Year 5 Estimated Outcome Amount: $1,264,624</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,407,360**
Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-12.1 Primary Care and Primary Prevention: Breast Cancer Screening |
| Unique RHP ID#: 112676501.3.1 – PASS 1 |
| Performing Provider: Nix Health Care System |
| Performing Provider TPI: 297342201 (old TPI 112676501) |

Outcome Measure Description:

**Outcome Measure**

IT-12.1 Breast Cancer Screening: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period (non-standalone measure)

- **Numerator:** Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.
- **Denominator:** Number of women aged 40 to 69 in the target population. Women who have had a bilateral mastectomy are excluded.

**Process Milestones**

- **DY2**
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
- **DY3**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for Each Year**

- **DY4**
  - IT-12.1: Improve Breast Cancer Screening Rate for Category 2.1 project patient population (% improvement TBD)
- **DY5**
  - IT-12.1: Improve Breast Cancer Screening Rate for Category 2.1 project patient population (% improvement TBD)

**Rationale:**

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after symptoms occur.

According to the American College of Radiology, Even for women over 50, skipping a mammogram every other year would miss up to 30% of cancers. Through the Medical Home Model, by taking a more active role in the health and disease prevention of their patients, physicians and support staff should proactively remind patients of the importance of preventive screenings is a key role in improving outcomes. This outcome measure is key to monitoring the success of those reminders.
P-1 was chosen since engaging stakeholders and identifying necessary resources is critical to the success of this outcome in subsequent years. P-2 was chosen since no baseline data currently exists. Baselines will be established in DY3 and improvement targets will be set for DY4-DY5.

**Improvement Targets**

Improvement targets will be established in DY3, along with the baseline rate, for implementation in DY4-DY5

**Outcome Measure Valuation:**

In order to value the effect of annual screening mammograms, we utilized a cost-avoidance approach. Treatment costs for breast cancer are considerably lower when a tumor is discovered at its early stages, which proves the economic value of screening mammograms. A recent California study showed that stage at diagnosis had an important impact on lifetime cancer-attributable costs, with costs increasing substantially for women diagnosed at later stages. Lifetime Medicare cancer-attributable costs increased from $21,320 for women diagnosed with in situ cancer, to $26,747 for localized cancer, $40,096 for regional cancer, and $52,288 for distant cancer\(^1\).

For every 1,000 screening mammograms, 5 patients will be diagnosed with breast cancer, according to the American College of Radiology\(^2\). So for every 1,000 screening mammograms that are done, the cost savings of catching the cancer early would be \(5 \times ($52,288 - $21,320)\). Assuming a patient panel of around 1,900 for DY2 and 50% female, we can estimate that roughly 5 cancers may be caught through annual screening mammograms at a cost savings of $154,840 for DY2.

In addition, the valuation criteria used for the corresponding Category 2 project are also applicable to this metric.

\(^1\) California Breast Cancer Research Program; The Cost of Breast Cancer in California  
http://cbcrp.org/research/PageGrant.asp?grant_id=2591

\(^2\) American College of Radiology; Mammography Saves Lives  
http://mammographysaveslives.org/Facts
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<td>Process Milestone 1 [P-1]</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
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<td>Data Source: Plans and agendas</td>
<td>Process Milestone Estimated Incentive Payment: $91,823</td>
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<td>Year 2 Estimated Outcome Amount: $79,217</td>
<td>Year 3 Estimated Outcome Amount: $91,823</td>
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<td>Year 5 Estimated Outcome Amount: $352,342</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $670,725**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-12.3: Colorectal Cancer Screening |
| Unique RHP ID#: 112676501.3.2 – PASS 1 |
| Performing Provider: Nix Health Care System |
| Performing Provider TPI: 297342201 (old TPI 112676501) |

### Outcome Measure Description:

**Outcome Measure**
- IT-12.2 Colorectal Cancer Screening (HEDIS 2012) Non-standalone measure
  - **Numerator**: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, flexible sigmoidoscopy every five years, Colonoscopy every 10 years.
  - **Denominator**: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded

**Process Milestones**
- **DY2**
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
- **DY3**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for Each Year**
- **DY4**
  - IT-12.3: Improve Colorectal Cancer Screening Rate for Category 2.1 project patient population (% improvement TBD)
- **DY5**
  - IT-12.3: Improve Colorectal Cancer Screening Rate for Category 2.1 project patient population (% improvement TBD)

### Rationale:

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after symptoms occur. Cancer is one of the leading causes of death in Region 6 and routine preventive screenings can help improve the outcomes for patients that are diagnosed with colon cancer by catching the cancer early.

**Process Milestones**

P-1 was chosen since engaging stakeholders and identifying necessary resources is critical to the success of this outcome in subsequent years. P-2 was chosen since no baseline data currently exists. Baselines will be established in DY3 and improvement targets will be set for DY4-DY5.
Improvement targets will be established in DY3, along with the baseline rate, for implementation in DY4-DY5

**Outcome Measure Valuation:**

In order to value the effect of routine screenings, we utilized a cost-avoidance approach. Treatment costs for colon cancer are considerably lower when a cancer is discovered at its early stages, which proves the economic value of screening exams. A recent study by the American Society of Clinical Oncology showed that stage at diagnosis had an important impact on lifetime cancer-attributable costs, with costs increasing substantially for those diagnosed at later stages. Lifetime cancer-attributable costs increased from $20,731 for those diagnosed with Stage I Colon cancer, to $24,038 for Stage II, $30,260 for Stage III, and $35,663 for Stage IV\(^1\).

The age-adjusted incidence rate is 0.05% of men and women per year\(^2\). So if the Medical Home has a panel of 1900 patients in DY2, it could be expected that 10 people may be diagnosed per year. Through preventive screenings, catching the colon or rectal cancer earlier would result in better outcomes and less costly treatments. So for every 1,000 colorectal screenings done, the cost savings of catching the cancer early would be 5*($35,663 minus $20,731). Assuming a patient panel of around 1,900 for DY2, we can estimate that roughly 5 cancers may be caught through annual screening at a cost savings of $74,660 for DY2 and increasing thereafter.

In addition, the valuation criteria used for the corresponding Category 2 project are also applicable to this metric.

\(^1\) American Society of Clinical Oncology; Estimating the Lifetime Cost of Treating Colon (C) and Rectal (R) Cancer in Canada.  
http://cbcrp.org/research/PageGrant.asp?grant_id=2591

\(^2\) National Cancer Institute; SEER Fact Sheets: Colon and Rectum  
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<td><strong>Process Milestone 5</strong> [P-2]: Establish baseline rates Data Source: Baseline data Process Milestone Estimated Incentive Payment: $91,823</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-12.3]: Colorectal Cancer Screening Rate Improvement Target: TBD DY2/DY3 Data Source: EMR Outcome Improvement Target Estimated Incentive Payment: $ 147,343</td>
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<td>Year 2 Estimated Outcome Amount: $ 79,217</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $670,725**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-12.4: Pneumonia Vaccination Status for Older Adults
Unique RHP ID#: 112676501.3.3 – PASS 1
Performing Provider: Nix Health Care System
Performing Provider TPI: 297342201 (old TPI 112676501)

Outcome Measure Description:

Outcome Measure
IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012) (Non-standalone measure)
  • Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine.
  • Denominator: Number of adults age 64 and older in the patient or target population.
Outcome improvement targets to be established in DY2 and DY3

Process Milestones
  • DY2
    • P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
  • DY3
    • P-2: Establish baseline rates

Outcome Improvement Targets for Each Year
  • DY4
    • for Category 2.1 project patient population (% improvement TBD)
  • DY5
    • IT-12.4: Improve Pneumonia Vaccination Status Rate for Category 2.1 project patient population (% improvement TBD)

Rationale:
The pneumonia vaccine prevents against 88% of the pneumococcal bacteria that cause pneumonia. People age 65 and older are at a high risk for bacterial pneumonia – two to three times more likely than the general population. Patients with chronic diseases, such as heart and lung disease or diabetes, are also at an increased risk. Of the patients over 65 that have pneumococcal pneumonia and develop bacteremia as a complication, and at least 20 % die from it, despite antibiotic treatment. Through vaccination, the risks can be lowered and outcomes improved.

Process Milestones
P-1 was chosen since engaging stakeholders and identifying necessary resources is critical to the success of this outcome in subsequent years. P-2 was chosen since no baseline data currently exists. Baselines will be established in DY3 and improvement targets will be set for DY4-DY5.

Improvement Targets
Improvement targets will be established in DY3, along with the baseline rate, for implementation in DY4-DY5
Outcome Measure Valuation:

In order to value the effect of pneumonia vaccinations, we utilized a cost-avoidance approach. The American Lung Association reported that the estimation of bacterial pneumonia occurrence in patients age 65 and older is 95 per 10,000 patients\(^1\). Based on the current Medicare rates, hospitalization for treatment of simple pneumonia without complications is $5,336 but treatment for cases with major complications is $11,334. If the patient develops bacteremia or septicemia, the cost of hospitalization can up over $14,000.

So in DY2 with approximately 1900 patients enrolled in the Medical Home, all of whom will be in the target age for a pneumonia vaccine, I could be estimated that 18 of them would suffer from bacterial pneumonia during the year. With vaccination, that number could easily be cut by 75%. With an assumed average cost per hospitalization of $11,000, and a reduction of 13.5 admissions, the value can be calculated conservatively at $148,500.

In addition, the valuation criteria used for the corresponding Category 2 project are also applicable to this metric.

\(^1\) American Lung Association; Pneumonia Fact Sheet
<table>
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<td><strong>Process Milestone 2</strong>&lt;br&gt;[P-2]: Establish baseline rates&lt;br&gt;Data Source: Baseline data&lt;br&gt;Process Milestone Estimated Incentive Payment: $91,823</td>
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<td>Year 2 Estimated Outcome Amount: $ 79,217</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $670,725</td>
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Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.1 Reduce All-Cause Readmission Rate
Unique RHP ID#: 112676501.3.4 – PASS 1
Performing Provider: Nix Health Care System
Performing Provider TPI: 297342201 (old TPI 112676501)

Outcome Measure Description:

Outcome Measure
IT-3.1 All cause 30 day readmission rate – NQF 1789 (standalone measure)
• Numerator: Unplanned all-cause 30-day readmissions to acute care facilities for patients aged 65 year or older
• Denominator: All Admissions to acute care facilities for patients aged 65 years or older

Process Milestones
• DY2
  • P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.
  • P-2: Establish baseline rates

Outcome Improvement Targets for Each Year
• DY3
  • IT-3.1 Reduce All-Cause Readmission Rate for applicable Category 2.8 project patient population (% reduction TBD)
• DY4
  • IT-3.1 Reduce All-Cause Readmission Rate for applicable Category 2.8 project patient population (% reduction TBD)
• DY5
  • IT-3.1 Reduce All-Cause Readmission Rate for applicable Category 2.8 project patient population (% reduction TBD)

Rationale:
This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge for patients aged 65 and older. Through our ACE Program, we will be implementing several process improvement initiatives aimed at improving the quality of care received by our elderly patients. Many of the steps that we will take during their hospitalization will also affect their readmission rate and we estimate that we will be able to greatly influence the all-cause readmission rate of the ACE Program patients. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Process Milestones
P-1 was chosen since engaging stakeholders and identifying necessary resources is critical to the success of this outcome in subsequent years. P-2 was chosen since no baseline data currently exists. Baselines will be established in DY2 and improvement targets will be set for DY3-DY5.

Improvement Targets
Improvement targets will be established in DY2, along with the baseline rate, for implementation in DY3-DY5.
Outcome Measure Valuation:

As stated by the NQF, "Multiple factors affect readmission rates and other measures including: the complexity of the medical condition and associated therapies; effectiveness of inpatient treatment and care transitions; patient understanding of and adherence to treatment plans; patient health literacy and language barriers; and the availability and quality of post-acute and community-based services, particularly for patients with low income. Readmission measurement should reinforce national efforts to focus all stakeholders’ attention and collaboration on this important issue." Our process improvement initiatives through the ACE program will address each of these issues and one of the primary measurable outcomes will be a reduction in preventable readmissions. Research has shown that an avoidable hospital readmission can mean prolonged illness, emotional distress, and loss of productivity for the patient. The factors mentioned above can be especially impactful on those of low income. According to the NQF, the national Medicare beneficiary all-cause readmission rate is around 20%, which costs about $15 billion annually.

In order to value the reduction in preventable readmissions, we utilized a cost-avoidance approach. In a recent ‘Solicitation for Applications’ by CMS for Community-based Care Transitions Programs, CMS recommended using $9,600 as the average cost of a hospital readmission\(^1\). While we will be establishing our baseline and targets in DY2, we expect that our ACE Program initiatives will reduce the readmission rate for the patients enrolled in the ACE program (assuming 533 in DY2 and increasing to 733 by DY5). Assuming the national average of 20%, a reduction to 15% would equate to 27 avoided readmissions in DY2 at a value of $259,200.

In addition, the valuation criteria used for the corresponding Category 2 project are also applicable to this metric.

\(^1\) CMS Solicitation for Applications: Community-based Care Transitions Program
<table>
<thead>
<tr>
<th>112676501.3.4 PASS 1</th>
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<td><strong>Outcome Improvement Target 1</strong> [IT-3.1]: All cause 30 day readmission rate (standalone measure) Improvement Target: TBD DY2 Data Source: Clinical Performer</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-3.1]: All cause 30 day readmission rate (standalone measure) Improvement Target: TBD DY2 Data Source: Clinical Performer</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,012,178**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-9.2: ED appropriate utilization (Standalone measure) for Diabetes |
| Unique RHP ID#: 112676501.3.5 – PASS 2 |
| Performing Provider: Nix Health Care System |
| Performing Provider TPI: 297342201 (old TPI 112676501) |

### Outcome Measure Description:

**Outcome Measure**

IT-9.2 ED appropriate utilization (Standalone measure) for the following targeted conditions:

- Diabetes

  - Numerator: Number of Patient Navigator enrollees with a diagnosis of one of the Diabetes that have one or more ED visit for diabetes during the measurement period
  - Denominator: All active Patient Navigator enrollees with a diagnosis of diabetes

**Process Milestones**

- **DY2**
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

- **DY3**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for Each Year**

- **DY4**
  - IT-9.2 Reduce percentage of ED utilization for diabetes for applicable Category 2.8 project patient population (% reduction TBD)

- **DY5**
  - IT-9.2 Reduce percentage of ED utilization for diabetes for applicable Category 2.8 project patient population (% reduction TBD)

### Rationale:

This measure estimates the impact that the Patient Navigator Program is having on helping patients receive the right care in the right setting. The Patient Navigators will help facilitate connections between patients and primary care physicians, as well as work with patients to identify outpatient and community resources available to them to help them manage their conditions on a proactive basis. These actions should lessen the occurrence of these patients presenting to the ED for treatment of their underlying conditions. Outcome improvement targets will be determined in DY3 for implementation in DY4.

**Process Milestones**

P-1 was chosen since engaging stakeholders and identifying necessary resources is critical to the success of this outcome in subsequent years. P-2 was chosen since no baseline data currently exists. Baselines will be established in DY3 and improvement targets will be set for DY4 and DY5.

**Improvement Targets**

Improvement targets will be established in DY3, along with the baseline rate, for implementation in DY4 and DY5.
Outcome Measure Valuation:

In 2005, Texas Health and Human Services Commission identified that 47.2% of the Medicaid emergency room visits were classified as non-emergent episodes. Often, patients seek care in an Emergency Department rather than in a Primary Care Physician’s office due to extended hours of operation, not being required to pay copays or deductibles before being treated or because they have not established a relationship with a PCP. HHSC determined that the state could have saved over $26M if patients had sought treatment for their non-emergent conditions through PCP offices instead. While the focus of this review was on conditions such as common cold, sore throat, vomiting, headache, etc., it still speaks to the point that developing a relationship with a PCP to treat non-urgent conditions can provide cost-savings opportunities across all patients.

Through the Patient Navigator Program, patients that are at high risk for disconnect from the system will be identified and enrolled in the program where they will be encouraged to utilize a primary care physician for their ‘medical home’ (even if the PCP is not formally a medical home accredited practice). These patients, who will likely have multiple medical conditions, will be connected with resources to assist them in managing any chronic or underlying conditions.

In order to value the program, we utilized a cost-avoidance approach and assumed each ED visit avoided would save of $1,318. Also, through more proactive management of their diseases, the patients’ general health will be improved. In addition, the valuation criteria used for the corresponding Category 2 project are also applicable to this metric.

1 Texas Health and Human Services Request for Information: Reducing Unnecessary Emergency Room Utilization 5/15/2008

2 Agency for Healthcare Research and Quality Medical Expenditure Panel Survey: Emergency Room Services
<table>
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<td>[P-2]: Establish baseline rates Data Source: Baseline data</td>
<td>[IT-9.2]: Reduce percentage of ED utilization for diabetes for applicable Category 2.8 project patient population • Numerator: # of Program enrollees with a diagnosis of diabetes that have one or more ED visits for diabetes during the measurement period • Denominator: All active enrollees with a diagnosis of diabetes Improvement Target: TBD DY2 Data Source: Clinical Performer</td>
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TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,075,333
### Identifying Outcome Measure and Provider Information:

**Title of Outcome Measure (Improvement Target):** IT-9.2 Reduce Emergency Department visits for target condition Diabetes  
**Unique RHP ID#:** 127294003.3.1 – PASS 1  
**Performing Provider:** Peterson Regional Medical Center  
**Performing Provider TPI:** 127294003

### Outcome Measure Description:

IT-9.2 Reduce Emergency Department visits for target condition Diabetes. OD-9 Right Care, Right Setting and IT 9.2 was chosen as the projects outcome domain based on 19% of overall diabetic population visits were in the Emergency Department setting.

Improved transition of care for the diabetic population can help reduce emergency department (ED) visits. High ED utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital EDs is extremely costly and care could be provided in less expensive settings. Patients resort to ED use for a variety of reasons: lack of regular or preventative care and inability to book timely follow-up appointments. Appropriate care transitions and patient education will provide diabetic patients with the tools and understanding to seek care with their primary care physician, clinic or specialist for non-emergency conditions. Patients who better understand their diabetes and the importance of continuity of their care will recognize the benefit of consistent, quality care.

### Process Milestones:

- **DY2:**  
  - P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**  
  - P-4 - Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

### Outcome Improvement Targets for Each Year:

- **DY4:**  
  - IT-9.2: Reduce total ED visits as a percentage of all diabetic visits by 5%
- **DY5**  
  - IT-9.2: Reduce total ED visits as a percentage of all diabetic visits by 5%

### Rationale:

Process milestones:
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans; and P-3 Develop and test data systems, were chosen because they coincide with the needs of process milestones that were set for Category 2. Therefore, in order to be successful and achieve desired outcomes it was decided that P-1 and P-4 would be the most appropriate to execute.

Outcome Improvement Targets:  
IT-9.2 Reduce Emergency Department visits for target condition Diabetes (standalone measure) will be executed in DY4 and DY5. 19% of overall diabetic population visits were in the Emergency Department setting. Proper implementation of Category 2 process improvements
within the diabetic population group will improve transition of care resulting in an expected decrease in emergency department visits for our diabetic population (regardless of primary reason for visit) by 5% in DY4 and an additional 5% in DY5.

**Outcome Measure Valuation:**

The implementation cost of this project, to include Categories 2 – 4, for DY1-DY2 is estimated to be $434,292 total. Each year thereafter has an estimated cost of $267,272 to continue project operations. In calendar year 2012 PRMC’s baseline diabetic population group had a total of 3,719 patients with 1,863 emergency department visits for a total of $3.73 million in charges. Once project outcomes have been reached, we estimate an average annual community healthcare savings of $373 thousand by reducing the ED total number of visits by 10% within our defined target group. This community savings comes from the amount of healthcare dollars that will be saved once the targeted population starts becoming more in control of their disease process and their self-management. Emergency Room resources will not be utilized as often and we anticipate seeing an increase in the use of outpatient services such as primary care visits and diabetic education resources provided within PRMC or the community. This project will address many of the discovered community health care needs by strategically implementing components of an evidence-based care transition model. With this process in place, we anticipate seeing an increase in diabetic patient self-managed care with improved care transitions reducing emergent and acute care needs.

This model will be used to assist in closing the gap in health care services of Kerr County residents causing them to utilize more costly inpatient services versus less costly outpatient services. The shortage of primary care in Kerr County has contributed to an increase us of inpatient services. Patients with chronic diseases who are not established with primary care provider are more likely to show up in the emergency department in crisis, which often results in an inpatient admission. The components of Project Red will prepare patients to better understand their disease process and address individual needs enabling them to better care for themselves. After a patient has been admitted to the hospital they are usually motivated to learn more about their illness; it is crucial that healthcare providers take advantage of this opportunity to educate and coordinate care during and beyond the hospital setting. This will allow patients to feel more involved and increasing potential compliance with their own healthcare needs. By utilizing a more patient-centered discharge model patients will experience more buy in to improve and maintain their own health at home.
<table>
<thead>
<tr>
<th>127294003.3.1 PASS 1</th>
<th>3.IT-9.2</th>
<th>Reduce Emergency Department visits for target condition Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterson Regional Medical Center</td>
<td>TPI - 127294003</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>127294003.2.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
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</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning</td>
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<tr>
<td><em>Data Source:</em> NIH, AHRQ, HCPro, Texas Hospital Quality, IOM, IHI, PCORI</td>
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</tr>
<tr>
<td>PM-1 Estimated Incentive Payment: $182,988</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Data Source:</em> Documentation of data management system and functionality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM-2 Estimated Incentive Payment: $212,107</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-9.2]: Reduce Emergency Department visits for target condition Diabetes</td>
<td></td>
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</tr>
<tr>
<td><em>Goal</em>: Reduce ED visits of the diabetic population group by 5%</td>
<td></td>
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</tr>
<tr>
<td><em>Numerator</em>: ED visits within diabetic population group</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Denominator</em>: Total visits within the diabetic population group</td>
<td></td>
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</tr>
<tr>
<td><em>Data Source</em>: EMR</td>
<td></td>
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<tr>
<td>Outcome IT-1 Estimated Incentive Payment: $340,358</td>
<td></td>
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<tr>
<td><strong>Outcome Improvement Target 2</strong> [IT-9.2]: Reduce Emergency Department visits for target condition Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Goal</em>: Reduce ED visits of the diabetic population group by 5%</td>
<td></td>
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<tr>
<td><em>Numerator</em>: ED visits within diabetic population group</td>
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</tr>
<tr>
<td><em>Denominator</em>: Total visits within the diabetic population group</td>
<td></td>
<td></td>
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<tr>
<td><em>Data Source</em>: EMR</td>
<td></td>
<td></td>
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<tr>
<td>Outcome IT-2 Estimated Incentive Payment: $813,899</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $182,988</td>
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<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $212,107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $340,358</td>
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<tr>
<td>Year 5 Estimated Outcome Amount: $813,899</td>
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<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $1,549,352</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.2 Reduce Emergency Department visits for target condition Diabetes
Unique RHP ID#: 127294003.3.4 – PASS 2
Provider Name: Peterson Regional Medical Center (PRMC)
TPI: 127294003

Outcome Measure Description:

IT-9.2 Reduce Emergency Department visits for target condition-Diabetes. OD-9 Right Care, Right Setting and IT 9.2 was chosen as the projects outcome domain based on 19% of overall diabetic population visits were in the Emergency Department setting. OD-9 Right Care, Right Setting and IT 9.2 was chosen as the projects outcome domain based on 19% of overall diabetic population visits were Emergency Department setting. One goal of collecting meaningful data is to identify the frequency and cost of care of emergency department visits in PRMC’s diabetic population group. Once proper reports are generated we can identify trends which contributed to diabetic patients not seeking the right care in the right setting.

- **Numerator:** ED visits within diabetic population group
- **Denominator:** Total visits within the diabetic population group
- **Data Source:** EMR
- **Rationale/Evidence:** If an organization is able to care for the patients in the appropriate setting, preventing unnecessary Emergency Department visits, admissions and/or readmissions, then cost of care will be cheaper in the lower intensity of service area.

Process Milestones:

**DY2:**
- P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources

**DY3:**
- P-4- Conduct PDSA cycles to improve data collection and intervention activities

Outcome Improvement Targets for Each Year:

**DY4:**
- IT-9.2 Reduce total ED visits as a percentage of all diabetic visits by 5%

**DY5**
- IT-9.2 Reduce total ED visits as a percentage of all diabetic visits by 5%

Rationale:

Process milestones:

P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans; and P-4 Conduct PDSA cycles to improve data collection and intervention activities, were chosen because they coincide with the needs of our process milestones that were set for Category 1.

Outcome Improvement Targets:

IT-9.2 Reduce Emergency Department visits for target condition-Diabetes (*standalone measure*) will be executed in DY4 and DY5. 19% of overall diabetic population visits were in the Emergency Department setting. Proper implementation of Pass I relies on successful Pass II implementation. Meaningful data collection is required to assure the process improvements within
the diabetic population group implemented in Pass I are working to improve transition of care resulting in an expected decrease in Emergency Department visits by 5% in DY4 and an additional 5% in DY5.

Outcome Measure Valuation:

In calendar year 2012 PRMC’s baseline diabetic population group had a total of 3,719 patients with 1,863 emergency department visits for a total of $3.73 million in charges. Once project outcomes have been reached from PASS I process improvements, we estimate an average annual community healthcare savings of $373 thousand by reducing the ED total number of visits by 10% within our defined target group. Meaningful data collection is required to assure the process improvements within the diabetic population group implemented in Pass I are working to improve transition of care resulting in an expected decrease in Emergency Department visits by 5% in DY4 and an additional 5% in DY5.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>[IT-9.2]: Reduce Emergency Department visits for target condition-Diabetes</td>
<td>[IT-9.2]: Reduce Emergency Department visits for target condition-Diabetes</td>
</tr>
<tr>
<td>Data Source: Process Improvement Database</td>
<td><strong>Goal:</strong> Reduce ED visits of the diabetic population group by 5%. <strong>Numerator:</strong> ED visits within diabetic population group <strong>Denominator:</strong> Total visits within the diabetic population group</td>
<td><strong>Goal:</strong> Reduce ED visits of the diabetic population group by 5%. <strong>Numerator:</strong> ED visits within diabetic population group <strong>Denominator:</strong> Total visits within the diabetic population group</td>
<td><strong>Goal:</strong> Reduce ED visits of the diabetic population group by 5%. <strong>Numerator:</strong> ED visits within diabetic population group <strong>Denominator:</strong> Total visits within the diabetic population group</td>
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<tr>
<td><strong>Data Source:</strong> Meditech</td>
<td><strong>Data Source:</strong> Meditech</td>
<td><strong>Data Source:</strong> Meditech</td>
<td><strong>Data Source:</strong> Meditech</td>
</tr>
</tbody>
</table>

**Year 2**
(10/1/2012 – 9/30/2013)

- Milestone 1 Estimated Incentive Payment: $48,732
- Milestone 2 Estimated Incentive Payment: $56,574

**Year 3**
(10/1/2013 – 9/30/2014)

- Milestone 1 Estimated Incentive Payment: $91,101
- Milestone 2 Estimated Incentive Payment: $56,574

**Year 4**
(10/1/2014 – 9/30/2015)

- Milestone 1 Estimated Incentive Payment: $91,101
- Milestone 2 Estimated Incentive Payment: $56,574

**Year 5**
(10/1/2015 – 9/30/2016)

- Milestone 1 Estimated Incentive Payment: $91,101
- Milestone 2 Estimated Incentive Payment: $56,574

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $413,997
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT- 8.2 Percentage of Low Birth-Weight Births |
| Unique RHP Outcome Identification Number: | 136491104.3.1 – PASS 1 |
| Performing Provider: | Southwest General Hospital |
| TPI: | 136491104 |

### Outcome Measure Description:

**IT- 8.2 Percentage of Low-Birth Weight Births**

Low birth weights will be defined as babies born weighing <2,500 grams at birth.

**Process Milestones:**

- **DY2:**
  - P-1 - Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
  - P-3 – Develop and test data systems

- **DY3:**
  - P-2 - Establish baseline rates
  - P-3 – Develop and test data systems

**Outcome Improvement Target for each year:**

- **DY4:**
  - IT-8.2 Percentage of Low-Birth Weight Births
    - Decrease the percentage of babies born weighing >2,500 grams at birth by mothers with Gestational Diabetes by 2% below baseline

- **DY5:**
  - IT-8.2 Percentage of Low Birth-Weight Births
    - Decrease the percentage of babies born weighing <2,500 grams at birth by 3% below baseline

### Rationale:

Process Milestones: P1 – P3 were chosen due to the lack of available systems to track and monitor percentages of low birth weights within the Iasis Healthcare Corporation. Identifying, testing, and analyzing available data sources are critical in DY2-DY-3. With the implementation of a sound database system, DY3 can then establish baseline low birth weight in the study population.

Improvement processes were chosen based on the timeframe allowed to put in place proper resources and processes needed to collect data. In addition the outcome measure being addressed is affected by multiple factors. Prenatal visit are critical to ongoing education and maintenance of this patient population. Through early identification and intervention screening, non diabetic mothers can be educated on the importance of prenatal care and working to achieve adequate health and maturation of the fetus.

It is anticipated that the incidence of low birth weight babies will decrease in the study population. DY 3 would serve as baseline for patients screened by the Gestational Diabetes
Team. DY 4 and DY 5 would demonstrate a low incidence of low birth weight babies as a result of the screening program and proper referral for diabetes care and/or appropriate prenatal care. The goal for the rate of decrease for low birth weight deliveries is conservatively set at 2% in the first year from baseline (DY4) and show gradual improvement in DY% to 3%.

**Outcome Measure Valuation:**

- **Addresses Community Needs:**

  As previously outlined the community and the RHP as a whole are critically challenged provide timely prenatal care and reduce the incidence of gestational diabetes. Of the 36,000 live births in RHP 6 in 2008, only 59% of mothers received prenatal care within the first trimester, leading to the assumption, access to medical care remains difficult regardless of clinic resources. The potential for gestational diabetes going unidentified is extremely high in the region. The screening, identification, education and provision of prenatal care are critical to impact the above outcome measures.

  **Project Scope:**

  Southwest General Hospital has a known reputation on the Southside of San Antonio related to obstetrical care. In late 2011, the organization launched a maternal fetal medicine program which has enhanced the ability to reach outlying regions and establish a program to identify and manage gestational diabetes in a manner which demonstrates practices based on evidence and supported by clinical outcomes. The expansion of the program to outlying communities will further enhance care but also extend high quality preventive care and education for the region. The program framework is developed and requires the expansion and planning to serve and identify a larger patient base and establish outreach programs to impact care for the patient population.

- **Project Investment:**

  Many of the resources required to support the physician component of the proposed project is in place. The major investment centers on midlevel care provider recruitment and salaries. Additionally, support staff, space, additional equipment needs, travel, marketing, and educational materials will require hospital dollars to support program implementation and sustainability.

RHP 6 Community Needs Assessment, September 2012.
<table>
<thead>
<tr>
<th>136491104.3.1 PASS 1</th>
<th>3.IT3.IT-8.2</th>
<th>Percentage of Low Birth Weight Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwest General Hospital</td>
<td>136491104.1.1</td>
<td>TPI - 136491104</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined in DY3</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3</strong> [P-3]: Develop and test data systems</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-8.2]: Percentage of Low Birth-Weight Births</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-8.2]: Percentage of Low Birth-Weight Births</td>
</tr>
<tr>
<td>Date Source: Information Technology reports database; Planning Team minutes and implementation plans</td>
<td>Data Source: HBI report system from McKesson</td>
<td>Improvement Target: Decrease the percentage of babies born weighing &lt;2,500 grams at birth by 2% below baseline</td>
<td>Improvement Target: Decrease the percentage of babies born weighing &lt;2,500 grams at birth by 3% below baseline</td>
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<tr>
<td>Goal: Identify existing and needed systems to gather low birth weight data</td>
<td>Goal: Establish low birth weight baseline data</td>
<td>Date Source: HBI report system from McKesson</td>
<td>Date Source: HBI report system from McKesson</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-3]: Develop and test data systems</td>
<td>Process Milestone 3 Estimated Incentive Payment $32,024.50</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $102,777</td>
<td><strong>Outcome Improvement Target 2</strong> Estimated Incentive Payment: $245,770</td>
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<tr>
<td>Data HBI report system from McKesson</td>
<td>Process Milestone 4 [P-2]: Establish baseline rate</td>
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<tr>
<td>Goal: Acquire needed systems to collect and analyze data for</td>
<td>Data Source: HBI report system from McKesson</td>
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<td></td>
<td>Process Milestone 3 Estimated Incentive Payment $32,024.50</td>
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<tr>
<td>low birth weight</td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment $27,763</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $55,256</td>
<td>Year 3 Estimated Outcome Amount: $64,049</td>
<td>Year 4 Estimated Outcome Amount: $102,777</td>
<td>Year 5 Estimated Outcome Amount: $245,770</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $467,852**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT 9.2 – ED appropriate utilization: Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension
Unique RHP Outcome Identification Number: 136491104.3.2 – PASS 1
Performing Provider: Southwest General Hospital
TPI: 136491104

Outcome Measure Description:

IT 9.2 – ED appropriate utilization: Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension

Process Milestones:
- **DY2:**
  - P-1 - Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-2 - Establish baseline rates
  - P-3 – Develop and test data systems

Outcome Improvement Target for each year:
- **DY4:**
  - Decrease the percentage of patients utilizing the Southwest General Hospital Emergency Department for Cardiovascular Disease/Hypertension by 3.5% from DY 3 baseline
- **DY5:**
  - Decrease the percentage of patients utilizing the Southwest General Hospital Emergency Department for Cardiovascular Disease/Hypertension by 7% from DY 4 baseline

Rationale:

Process Milestones: P1 – P3 were chosen due to the lack of available systems to track and monitor percentages of ED utilization for specific disease entities within the Iasis Healthcare Corporation. Identifying, testing, and analyzing available data sources are critical in DY2-DY-3. With the implementation of a sound database system, DY3 can then establish baseline ED utilization for identified diagnoses related to Cardiovascular Disease/Hypertension.

Improvement processes were chosen based on the timeframe allowed to put in place proper resources and processes needed to collect data. In addition, the outcome measure being addressed is affected by multiple factors. Through early identification and intervention of screened residents for cardiovascular disease, intervention, further testing, and treatment can be implemented to impact disease progression and symptom management. A community impact on ED utilization from communities of the RHP 6 region participating in screening clinics will be evaluated for utilization.

It is predicted that the utilization of the ED will decrease in the study population. DY 3 would serve...
Outcome Measure Valuation:

Achieve Waiver Goals:

Waiver goals include increasing 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.

In support of the goal, Southwest General Hospital will develop a mobile specialty care unit dedicated to vascular screening. Through this service the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. The program will provide a mobile vascular screening service which will provide non-invasive screenings. Tests will be performed by vascular technologists. Results and follow-up plan, as necessary, provided at the time of screening.

Addresses Community Needs:

As previously stated, early identification and management of potential life threatening cardiovascular conditions (Stroke; Carotid Artery Disease; Peripheral Vascular Insufficiency, as well as access for services and treatment otherwise not available is critical to meeting the healthcare needs of RHP 6. The shortage of health care providers has led to high emergency room utilization. This is a very costly means of health care delivery, and often results in a delay seeking treatment until the illness is severe and advanced. In addition, access to primary care has become increasingly difficult within the region, resulting in poor overall management of the population’s health. Through the development of a mobile specialty care unit by Southwest General Hospital, dedicated to vascular screening, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner.

Project Scope:

Southwest General Hospital has provided care to the residents of South San Antonio since 1978. In late 2012, the organization achieved Chest Pain Accreditation and currently is preparing for PCI Accreditation with the Center. The expansion of the program to outlying communities will further enhance care but also extend high quality preventive care and education for the region. The program framework for cardiovascular services is developed and supports acute care needs for the area. Program development requires the expansion and planning to serve and identify a larger patient base and establish outreach programs to impact care for the patient population. Through the development of a mobile specialty care unit by Southwest General Hospital, dedicated to vascular screening, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner.
Project Investment:

Many of the resources required to support the physician component of the proposed project is in place. The need to recruit and hire midlevel care providers is a key investment in manpower to support the endeavor. The purchase of additional noninvasive diagnostic equipment and a van to support the program will be a $190,000 investment by Southwest General Hospital to launch the program for its current patient population and the RHP 6 proposed project.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Develop and test data systems</td>
<td>ED utilization \RED {Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension}</td>
</tr>
<tr>
<td>Date Source: Information Technology reports database; Planning Team minutes and implementation plans/ Coral ED System</td>
<td>Data Source: HBI report system from McKesson/Coral ED System</td>
<td>Improvement Target: Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension by 7% from DY 4 baseline</td>
</tr>
<tr>
<td>Goal: Identify existing and needed systems to gather ED utilization data for target patient populations</td>
<td>Goal: Collaborate with Information Technology to develop and test systems for data collection for ED utilization</td>
<td>Date Source: HBI report system from McKesson/Coral ED System</td>
</tr>
<tr>
<td>Baseline: Lack of needed resources to evaluate impact of ED utilization for project</td>
<td>Baseline: Lack of developed and tested systems to collect baseline data and ongoing study data needs</td>
<td>Goal: Decrease ED utilization rate of targeted population by 5% from DY 4 Baseline: ED DY 3 ED utilization rates</td>
</tr>
</tbody>
</table>

**Process Milestone 2**

[P-3]: Develop and test data systems to measure ED utilization for target population

**Process Milestone 3**

[P-3]: Develop and test data systems

**Outcome Improvement Target 1**

[IT-9.2]: Appropriated ED utilization: Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Outcome Improvement Target 2**

[IT-9.2]: ED utilization \RED {Reduce ED visits for target conditions: Cardiovascular Disease/Hypertension}
<table>
<thead>
<tr>
<th>Data Source: HBI report system from McKesson/Coral ED System</th>
<th>Goal: Establish ED utilization baseline rates for target population</th>
<th>Baseline: Lack of appropriate equipment and systems to collect and analyze data for ED utilization</th>
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<tbody>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment $27,763</td>
<td>Process Milestone 4 Estimated Incentive Payment $32,025</td>
<td>Year 2 Estimated Outcome Amount: $55,256</td>
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<td>Year 4 Estimated Outcome Amount: $102,777</td>
<td>Year 5 Estimated Outcome Amount: $245,770</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $467,851**
Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group: Improvement in LTBI treatment completion</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number(s): 133257904.3.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider Name: Texas Center for Infectious Disease</td>
</tr>
<tr>
<td>TPI: 133257904</td>
</tr>
</tbody>
</table>

Outcome Measure Description:

IT- 11.1 Improvement in Clinical Indicator in identified disparity group

Process Milestones:

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY3:**
  - P-2 – Establish baseline rates for rate 1 and rate 2

Outcome Improvement Targets for each year:

- **DY4:**
  - IT-11.1: Improvement in clinical indicator in identified disparity group. Improvement Target: 3% improvement in LTBI treatment completion by TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline

- **DY5:**
  - IT-11.1: Improvement in clinical indicator in identified disparity group. Improvement Target: 5% improvement in LTBI treatment completion by TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline

Rationale:

Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve comprehensive, evidence based TB care of TB for urban and rural minority communities in Texas. This initiative will undertake a series of steps which incorporate core project components to achieve this collaboration between Department of State Health Services (DSHS), The University of Texas Health Science Center at Tyler (UTHSCT), Texas Center for Infectious Disease (TCID) and the Heartland National TB Center (HNTC) as follows:

1) Provide predictable and reliable expert physician support for DSHS personnel at all levels of TB care.
2) Increase overall access to TB care by minority populations
3) Increase targeted testing for LTBI in high risk minority communities
4) Provide routine testing for LTBI with interferon gamma release assays instead of tuberculin skin testing to minimize false positive tests in BCG vaccinated patients and avoid unnecessary LTBI therapy
5) Provide routine treatment of LTBI through a 12 dose, 12 week regimen administered by DOT to...
improve patient adherence with and completion of LTBI therapy
6) Provide expert consultation and direct patient oversight of all active TB cases
7) Facilitate continuity of TB care through all phases including LTBI therapy, outpatient TB therapy and, when necessary, inpatient therapy
8) Facilitate hospitalization for TB care of those few patients who cannot be successfully treated as outpatients
9) Provide a model for statewide TB management through complete integration of TB resources between DSHS (TCID) and UTHSCT, including HNTC.

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, the standalone measure selected was IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider. The disparity group is minority (Black and Hispanic) urban and rural populations at risk for TB in DSHS HSR #8 and #4/5N. The clinical indicators to be improved include 1) percentage of TB patients receiving therapy of active TB by DOT and 2) improved LTBI treatment completion rates.

**Outcome Measure Valuation:**

This represents an innovative and ambitious project to enhance and expand the control of TB in minority communities in 2 DSHS Health Service Regions (HSRs) in Texas that encompass both urban and rural minority populations. This proposal incorporates the existing public health infrastructure of DSHS and the extensive TB expertise of UT physicians at UTHSCT, TCID and HNTC in a collaboration that promotes expert, cost-effective, evidence-based TB control with seamless continuity of care at every level. The expertise of UT physicians with evidence-based CDC and DHHS treatment guidelines insures avoidance of unnecessary and costly diagnostic and treatment strategies while the application of new diagnostic (IGRA testing) and treatment strategies (12 week LTBI therapy) further reduce costs by focusing resources on interventions of proven public health value at a lower financial cost. The value of this project is justifiable on the basis of:

1) Enhanced access to a comprehensive fully integrated TB care process that utilizes the existing DSHS public health infrastructure and physician expertise from UT.
2) Implementation of universal LTBI testing with IGRA thereby limiting the expense and potential drug toxicity of false + TSTs in BCG vaccinated populations.
3) Implementing universal 12 week, 12 dose LTBI therapy to improve LTBI treatment completion rates over baseline, 3% in DY 4 and 5% in DY 5, and decrease future TB burden.
4) Insure universal application of evidence based treatment guidelines from CDC and DHHS for LTBI and TB disease and improve active TB disease therapy completion rates over baseline, 3% in DY 4 and 5% in DY 5.
5) The DY 4 and DY 5 targets for the proposed strategies were determined by considering recent trends in LTBI and TB disease epidemiology in Texas and the funding available for the state TB program, both of which have been relatively unchanged with a realistic assessment of the potential for any intervention to significantly improve in the context of these static trends.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>133257904.2.1</td>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-11.1]: Improvement in Clinical Indicator in Identified Disparity Group</td>
<td>Outcome Improvement Target 2 [IT-11.1]: Improvement in Clinical Indicator in Identified Disparity Group</td>
</tr>
<tr>
<td></td>
<td>Data Source: EHR reports</td>
<td>Data Source: EHR; Business Intelligence</td>
<td>Improvement Target: 3% improvement in LTBI treatment completion by TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline</td>
<td>Improvement Target: 5% improvement in LTBI treatment completion by TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $255,877</td>
<td>Process Milestone 2 Estimated Incentive Payment: $192,317</td>
<td>Data Source: EHR; Business Intelligence</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment $384,634</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment $856,200</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $255,877</td>
<td>Year 3 Estimated Outcome Amount: $192,317</td>
<td>Year 4 Estimated Outcome Amount: $384,634</td>
<td>Year 5 Estimated Outcome Amount: $856,200</td>
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</tbody>
</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group: Improvement in therapy of active TB
Unique RHP outcome identification number(s): 133257904.3.2 – PASS 1
Performing Provider Name: Texas Center for Infectious Disease
TPI: 133257904

Outcome Measure Description:

IT-11.1 Improvement in Clinical Indicator in identified disparity group

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- DY3:
  - P-2 – Establish baseline rates for rate 1 and rate 2

Outcome Improvement Targets for each year:

- DY4:
  - IT-11.1 Improvement in clinical indicator in identified disparity group. Improvement Target: 3% improvement in therapy of active TB by DOT of TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline

- DY5:
  - IT-11.1 Improvement in clinical indicator in identified disparity group. Improvement Target: 5% improvement in therapy of active TB by DOT of TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline

Rationale:

Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve comprehensive, evidence based TB care of TB for urban and rural minority communities in Texas. This initiative will undertake a series of steps which incorporate core project components to achieve this collaboration between Department of State Health Services (DSHS), The University of Texas Health Science Center at Tyler (UTHSCT), Texas Center for Infectious Disease (TCID) and the Heartland National TB Center (HNTC) as follows:

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2) Increase overall access to TB care by minority populations
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4) Provide routine testing for LTBI with interferon gamma release assays instead of tuberculin
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5) Provide routine treatment of LTBI through a 12 dose, 12 week regimen administered by DOT to improve patient adherence with and completion of LTBI therapy
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Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, the standalone measure selected was IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider. The disparity group is minority (Black and Hispanic) urban and rural populations at risk for TB in DSHS HSR #8 and #4/5N. The clinical indicators to be improved include 1) percentage of TB patients receiving therapy of active TB by DOT and 2) improved LTBI treatment completion rates.

**Outcome Measure Valuation:**

This represents an innovative and ambitious project to enhance and expand the control of TB in minority communities in 2 DSHS Health Service Regions (HSRs) in Texas that encompass both urban and rural minority populations. This proposal incorporates the existing public health infrastructure of DSHS and the extensive TB expertise of UT physicians at UTHSCT, TCID and HNTC in a collaboration that promotes expert, cost-effective, evidence-based TB control with seamless continuity of care at every level. The expertise of UT physicians with evidence-based CDC and DHHS treatment guidelines insures avoidance of unnecessary and costly diagnostic and treatment strategies while the application of new diagnostic (IGRA testing) and treatment strategies (12 week LTBI therapy) further reduce costs by focusing resources on interventions of proven public health value at a lower financial cost. The value of this project is justifiable on the basis of:

1) Enhanced access to a comprehensive fully integrated TB care process that utilizes the existing DSHS public health infrastructure and physician expertise from UT.
2) Implementation of universal LTBI testing with IGRA thereby limiting the expense and potential drug toxicity of false + TSTs in BCG vaccinated populations.
3) Implementing universal 12 week, 12 dose LTBI therapy to improve LTBI treatment completion rates over baseline by 3% in DY 4 and 5% in DY 5 to decrease future TB burden.
4) Insure universal application of evidence based treatment guidelines from CDC and DHHS for LTBI and TB disease to improve TB disease treatment completion rates over baseline by 3% in DY 4 and 5% in DY 5.
5) The DY 4 and DY 5 targets for the proposed strategies were determined by considering recent trends in LTBI and TB disease epidemiology in Texas and the funding available for the state TB program, both of which have been relatively stable with a realistic assessment of the potential for any intervention to significantly improve those static trends.
<table>
<thead>
<tr>
<th>133257904.3.2 PASS 1</th>
<th>3.IT-11.1</th>
<th>Improve Clinical Indicator in identified disparity group: Improvement in therapy of active TB</th>
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<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>133257904.2.1</td>
<td>TPI - 133257904</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment: $255,876</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates Data Source: EHR; Business Intelligence Process Milestone 2 Estimated Incentive Payment: $192,318</td>
<td>Outcome Improvement Target 1 [IT-11.1]: Improvement in Clinical Indicator in Identified Disparity Group Improvement Target: 3% improvement in therapy of active TB by DOT of TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 1 Estimated Incentive Payment: $384,635</td>
<td>Outcome Improvement Target 2 [IT-11.1]: Improvement in Clinical Indicator in Identified Disparity Group Improvement Target: 5% improvement in therapy of active TB by DOT of TB patients in urban DSHS Region 8 and rural DSHS Region 4/5N relevant minority populations over baseline Data Source: EHR; Business Intelligence Outcome Improvement Target 3 Estimated Incentive Payment: $856,200</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $255,876 Year 3 Estimated Outcome Amount: $192,318 Year 4 Estimated Outcome Amount: $384,635 Year 5 Estimated Outcome Amount: $856,200

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,689,029
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-8.1 Timeliness of Prenatal/Postnatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID: 136141205.3.1 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: University Hospital</td>
</tr>
<tr>
<td>TPI: 136141205</td>
</tr>
</tbody>
</table>

## Outcome Measure Description:

The proposed program will address the Category 3 outcome measure associated with timeliness of prenatal/postnatal care within the first trimester (or within 42 days) of enrollment in the organization and a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days post delivery. This measure is a CHIPRA Core Measure/NQF #1517).

IT-8.1 Timeliness of Prenatal/Postnatal Care262 (CHIPRA Core Measure/NQF #1517) *(Non-stand alone measure)*

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

b. Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year

c. Data source: EHR, claims

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

## Process Milestones:

- **P-1** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **P-2** Establish baseline rates

## Outcome Improvement Targets for each year

In DY4: Increase the timeliness of prenatal/postnatal care for women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year by TBD% from baseline
In DY5: Increase the timeliness of prenatal/postnatal care for women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year by TBD% from baseline

**Rationale:**
Early initiation of Prenatal Care (PNC) during pregnancy has been shown to significantly reduce the potentially deleterious effects of both normal and high-risk pregnancy outcomes including: 1) premature birth, 2) low birth weight, 3) maternal hypertension and 4) gestational diabetes (Alexander and Korenbrot, 1995; Tossounian, Schoendorf and Kiely, 1997; Alexander and Kotelchuck, 2001; Atrash et al., 2006). In addition, the delivery of postnatal care primarily through preventive screening conducted at specific developmental milestones can help reduce maternal death or disability as a result of undiagnosed conditions (Healthy People 2020). Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3. After the baseline is established, goals will be set for outcomes measured in DY 4 and DY5. We expect to increase timeliness of prenatal/postnatal care by 5% in DY 4 and DY5 from the previous year for Northwest clinic patients.

**Outcome Measure Valuation:**
Increasing access to prenatal and postnatal care is central to improving preventive health services that respond to the needs of an underserved, largely Hispanic population. Many women in our target population struggle with poverty, receive only acute or emergency healthcare services, and do not have an established relationship with a provider. Increased access to primary care allows women much needed prenatal care and education aimed at improving maternal and child health in Bexar County, Texas.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>136141205.1.1</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>P- 2 Establish baseline rates for timeliness of prenatal/postnatal care</td>
<td>IT-8.1 Timeliness of Prenatal/Postnatal Care</td>
<td>IT-8.1 Timeliness of Prenatal/Postnatal Care</td>
</tr>
<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: Sunrise, IDX, Quality reports</td>
<td>Improvement Target: Increase the timeliness of prenatal/postnatal care for women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year by TBD% from baseline</td>
<td>Improvement Target: Increase the timeliness of prenatal/postnatal care for women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year by TBD% from baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $175,681</td>
<td>Process Milestone 2 Estimated Incentive Payment: $203,637</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $326,767</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $781,400</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $175,681</td>
<td>Year 3 Estimated Outcome Amount: $203,637</td>
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<td>Year 5 Estimated Outcome Amount: $781,400</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,487,485**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-8.5 Frequency of ongoing prenatal care |
| Unique RHP ID: | 136141205.3.2 – PASS 1 |
| Performing Provider: | University Hospital |
| TPI: | 136141205 |

### Outcome Measure Description:

The proposed program will address the Category 3 outcome measure associated with frequency of ongoing prenatal care. Medicaid-enrolled women who had live births during the past year will be tracked to determine the percentage of recommended prenatal visits they had. Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems. This measure is AHRQA266/CHIPRA267.

**IT-8.5 Frequency of ongoing prenatal care (AHRQ266/CHIRPA267) (Non-stand alone measure)**

- **a. Numerator:** Women in the denominator sample who had an unduplicated count of less than 21%, 21-40%, 41-60%, 61-80%, or more than 81% of expected visits, adjusted for the month of pregnancy at enrollment and gestational age.
- **b. Denominator:** Women who delivered a live birth during the measurement yr.
- **c. Data source:** EHR, Claims
- **d. Rationale/Evidence:** This measure looks at the use of prenatal care services. It tracks Medicaid-enrolled women who had live births during the past year to determine the percentage of recommended prenatal visits they had. Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems. The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early as possible in the first trimester of pregnancy. Visits should follow a schedule.
  - Every 4 weeks for the first 28 weeks of pregnancy
  - Every 2 to 3 weeks for the next 7 weeks
  - Weekly thereafter until delivery

### Process Milestones:

- **P-1 Project planning** - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **P-2 Establish baseline rates**

#### Outcome Improvement Targets for each year

In DY4: Increase the frequency of ongoing prenatal care for women who had live births during the measurement year by TBD% from baseline

In DY5: Increase the frequency of ongoing prenatal care for women who had live births during the measurement year by TBD% from baseline
**Rationale:**

It is estimated that every year nearly one million American women deliver babies without receiving adequate medical care. Studies find that babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care (Health Resources and Services Administration, 2012). Early initiation of prenatal care (PNC) during pregnancy has been shown to significantly reduce the potentially deleterious effects of both normal and high-risk pregnancy outcomes including: 1) premature birth, 2) low birth weight, 3) maternal hypertension and 4) gestational diabetes (Alexander and Korenbrot, 1995; Tossounian, Schoendorf and Kiely, 1997; Alexander and Kotelchuck, 2001; Atrash et al., 2006).

In addition, the risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and interconception (between pregnancies) care (Healthy People 2020). Evidence further suggests that facilitation of healthy decision-making by individuals can be enhanced through timely access to interventions that encourage group support, adherence to preventive care, and positive interactive dialogue. Within the areas of maternal health and clinical preventive services, the 2011 National Prevention Strategy recommends health service interventions that support a healthy pregnancy through timely and ongoing access/early entry into clinical preventive care alongside systems of support that address the individual’s social and emotional well-being (Department of Health and Human Services, 2011). Combined, these practices can encourage and empower individuals to make healthy decision-making that can lead to improved health outcomes for both the mother and child.

Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3. After the baseline is established, goals will be set for outcomes measured in DY 4 and DY5. We expect to decrease the rate of women who receive late or no prenatal care by TBD% in DY 4 and DY5.

**Outcome Measure Valuation:**

Increasing the proportion of women who receive ongoing prenatal care is central to responding to the needs of an underserved, largely Hispanic population. Many women in our target population struggle with poverty, receive only acute or emergency healthcare services only, and do not have an established relationship with a provider. Increased access to primary care allows women much needed prenatal care and education aimed at improving maternal and child health in Bexar County, Texas.
<table>
<thead>
<tr>
<th>136141205.3.2 PASS 1</th>
<th>3.IT-8.5</th>
<th>Frequency of ongoing prenatal care (AHRQ266/CHIRPA267)(Non-stand alone measure)</th>
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</thead>
<tbody>
<tr>
<td>University Hospital</td>
<td>TPI - 136141205</td>
<td></td>
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</table>

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:** To be developed in DY3

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>P-2 Establish baseline rates for frequency of ongoing prenatal care. Data Source: Sunrise, IDX, Quality reports</td>
<td>IT-8.5 Frequency of ongoing prenatal care Improvement Target: Increase the frequency of ongoing prenatal care for women who had live births during the measurement year by TBD% from baseline Data Source: Quality Dashboards, Data Analytic Reports, EMR</td>
<td>IT-8.5 Frequency of ongoing prenatal care Improvement Target: Increase the frequency of ongoing prenatal care for women who had live births during the measurement year by TBD% from baseline Data Source: Quality Dashboards, Data Analytic Reports, EMR</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,487,487**
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-8.2: Percentage of Low-Birth Weight births (CHIPRA/NQF#1382) Standalone Measures</th>
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<tbody>
<tr>
<td>Unique RHP ID#: 136141205.3.3 – PASS 1</td>
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<tr>
<td>Performing Provider: University Hospital</td>
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<tr>
<td>TPI: 136141205</td>
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</table>

**Outcome Measure Description:**

**IT-8.2 Percentage of Low Birth Weight Births**

Numerator: the number of babies born weighing <2,500 grams at birth  
Denominator: All births  
Data source: HER, claims

**Process Milestones:**

- **P-1** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **P-2** Establish baseline rates

**Outcome Improvement Targets for each year**

- In DY4: Decrease percentage of low birth weight births by TBD% from baseline

- In DY5: Decrease percentage of low birth weight births by TBD% from baseline

**Rationale:**

It is estimated that every year nearly one million American women deliver babies without receiving adequate medical care. Studies find that babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care (Health Resources and Services Administration, 2012). Early initiation of Prenatal Care (PNC) during pregnancy has been shown to significantly reduce the potentially deleterious effects of both normal and high-risk pregnancy outcomes including: 1) premature birth, 2) low birth weight, 3) maternal hypertension and 4) gestational diabetes (Alexander and Korenbrot, 1995; Tossounian, Schoendorf and Kiely, 1997; Alexander and Kotelchuck, 2001; Atrash et al., 2006). In addition, the delivery of postnatal care primarily through preventive screening conducted at specific developmental milestones can help reduce maternal death or disability as a result of undiagnosed conditions (Healthy People 2020).

Evidence further suggests that facilitation of healthy decision-making by individuals can be enhanced through timely access to interventions that encourage group support, adherence to preventive care, and positive interactive dialogue. Within the areas of maternal health and clinical preventive services, the 2011 National Prevention Strategy recommends health service interventions that support a healthy pregnancy through timely and ongoing access/early entry into clinical preventive care alongside systems of support that address the individual’s social and...
emotional well-being (Department of Health and Human Services, 2011). Combined, these practices can encourage and empower individuals to make healthy decision-making that can lead to improved health outcomes for both the mother and child.

Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3. After the baseline is established, goals will be set for outcomes measured in DY 4 and DY 5. We expect to decrease the rate of women who receive late or no prenatal care by TBD% in DY 4 and DY 5.

**Outcome Measure Valuation:**

Decreasing low birth weight is central to responding to the needs of an underserved, largely Hispanic population. Many women in our target population struggle with poverty, receive only acute or emergency healthcare services only, and do not have an established relationship with a provider. Increased access to primary care allows women much needed prenatal care and education aimed at improving maternal and child health in Bexar County, Texas.
<table>
<thead>
<tr>
<th>136141205.3.3</th>
<th>3.IT-8.2</th>
<th>IT-8.2: Percentage of Low-Birth Weight births (CHIPRA/NQF#1382)</th>
</tr>
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<tbody>
<tr>
<td>PASS 1</td>
<td>University Hospital</td>
<td>TPI - 136141205</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
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</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
</tbody>
</table>
| Process Milestone 1  
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Meeting minutes | Process Milestone 2  
P- 2 Establish baseline rates for percentage of low birth weight births.  
Data Source: Sunrise, IDX, Quality reports | Outcome Improvement Target 1  
IT-8.2 Percentage of Low-Birth Weight Births (CHIPRA/NQF#1382)  
Improvement Target: Decrease percentage of low-birth weight births (CHIPRA/NQF#1382) by TBD% from baseline.  
Denominator: All Births  
Data Source: Quality Dashboards, Data Analytic Reports, EMR, claims | Outcome Improvement Target 2  
IT-8.2 Percentage of Low-Birth Weight Births (CHIPRA/NQF#1382)  
Improvement Target: Decrease percentage of low-birth weight births (CHIPRA/NQF#1382) by TBD% from baseline.  
Denominator: All Births  
Data Source: Quality Dashboards, Data Analytic Reports, EMR |
| Process Milestone 1  
Estimated Incentive Payment: $175,681 | Process Milestone 2  
Estimated Incentive Payment: $203,637 | Outcome Improvement Target 1  
Estimated Incentive Payment: $326,768 | Outcome Improvement Target 2  
Estimated Incentive Payment: $781,401 |
| Year 2 Estimated Outcome Amount: $175,681 | Year 3 Estimated Outcome Amount: $203,637 | Year 4 Estimated Outcome Amount: $326,768 | Year 5 Estimated Outcome Amount: $781,401 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,487,487** |
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization (standalone measure)
Unique RHP ID#: 136141205.3.4 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT-9.2 ED appropriate utilization *(Standalone measure)*
- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3. After baseline established, goals will be set for outcomes measure in DY 4 and DY5.

Process Milestones:
DY2:
  P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

DY3:
P-2- Establish baseline rates for reduction in ED visits for targeted conditions

Outcome Improvement Targets for each year:
DY4:
  Reduce ED visits for targeted conditions by a TBD percentage from baseline Y3.

DY5:
  Reduce ED visits for targeted conditions by a TBD percentage from baseline Y3.

Rationale:
High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The targeted population will be the CareLink members assigned to University Health System patient centered medical homes. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between
member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

Process Milestones P1 and P2 were chosen to allow time for necessary project planning and data collection activities to understand our patients who will benefit the most from expanded primary care into their neighborhoods. It will also allow us to set up the necessary processes to effectively reach out and work with chronic disease patient as we expand our primary care capacity.

The improvement targets of reducing avoidable ED visits for specific medical conditions selected because of the evidence base associated with access to primary care and the reduction of unnecessary ED visits. Having a regular source of primary care increases the probability that patients with chronic medical conditions will have less exacerbations, better control of their disease, and therefore fewer ED visits caused by uncontrolled symptoms. Since this is an expansion of primary care in an existing patient population we know which patients to target for more outreach, and care management to reach our goals.

**Outcome Measure Valuation:**

This outcome will be valued based on the number of emergency visits avoided by patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma. The rational is expanded primary care and acute care through University Health System’s ExpressMed clinics will support patients in controlling these chronic conditions and reduce avoidable emergency center visits. It will also support the achievement of Waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>136141205.1.2</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
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</table>

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline: 0 Data Source: Meeting minutes</td>
<td>P- 2 Establish baseline rates for reduction in ED visits for targeted conditions Metric 1: Number of annual ER visits for CareLink patients with COPD, behavioral health, diabetes and asthma. Data Source: Sunrise, IDX, volume reports, Quality reports</td>
<td>IT-9.2 ED appropriate utilization: Improvement Target: Reduce ED visits for targeted conditions by TBD % from baseline Y3. Baseline: Y3 ER visits and avoidable ER visits for targeted conditions. Data Source: Quality, Sunrise, volume reports</td>
<td>IT-9.2 ED appropriate utilization: Improvement Target: Reduce ED visits for targeted conditions by TBD % from baseline Y3. Baseline: Y3 ER visits and avoidable ER visits for targeted conditions. Data Source: Quality, Sunrise, volume reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $554,784</td>
<td>Process Milestone 2 Estimated Incentive Payment: $643,067</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,031,897</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $2,467,580</td>
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</tbody>
</table>

| Year 2 Estimated Outcome Amount: $554,784 | Year 3 Estimated Outcome Amount: $643,067 | Year 4 Estimated Outcome Amount: $1,031,897 | Year 5 Estimated Outcome Amount: $2,467,580 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,697,328**
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-9.2 ED appropriate utilization <em>(Standalone measure)</em></th>
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<tbody>
<tr>
<td>Unique RHP identification number:</td>
<td>136141205.3.5 – PASS 1</td>
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<tr>
<td>Performing Provider:</td>
<td>University Hospital</td>
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<tr>
<td>TPI:</td>
<td>136141205</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**IT-9.2 ED appropriate utilization *(Standalone measure)***
- Reduce all ED visits (including ACSC)271
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

**Process Milestones**
- **DY2**
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY3**
  - P-3: Develop and test data systems.

**Improvement Targets**
- **DY4**
  - IT-9.2: Reduce Emergency Department visits by 5% (300 visits/yr) for adult and pediatric asthma/COPD registry patients assigned to three target clinics

- **DY5**
  - IT-9.2: Reduce Emergency Department visits by 15% for adult and pediatric asthma/COPD registry patients assigned to three target clinics

### Rationale:
The rationale for selecting the following process milestones reflect the methodical approach that will be undertaken to engage stakeholder, identify needed resources, develop an implementation and project monitoring plan to ensure an appropriate alignment with improving and reporting of data and systems to produce performance measures that accurately reflect ED appropriate utilization.

**Process Milestones**
Process Milestone 1, Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans, ensures that the appropriate resources and personnel are available to provide data synthesis and reporting.

The Health System is in the early stages of its Population Health Infrastructure Initiative (PHII) and creating the registry for asthma under the Waiver will be a new activity. Process milestone 2, Develop and test data systems, was chosen as a critical step in the registry development process, allowing for rapid cycle improvements where appropriate prior to implementation.

**Improvement Targets**

This outcome improvement measure was chosen for its direct relation to the goals of the Waiver by a) improve the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further develop and maintain a coordinated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

**Outcome Measure Valuation:**

Success of the registry program in the form of reduced ED utilization for asthma/COPD patients will be an indicator for achievement of Waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth). When fully implemented – beyond DY5 – which includes registries for other highly prevalent chronic conditions, such as diabetes and CHF, as well as eventually sharing the technology among the region’s Performing Providers, the larger scope of the project should impact proper utilization in the form of increased routine and follow-up patient visits and encounters and reduced ED utilization. This project requires investment as it is an enhancement to current HIE funding goals. The hardware, software applications, human resources, and time to implement are of the highest organizational priority for the Health System. This particular project targets asthma/COPD, but the scope of utilization for other chronic diseases and in other health care settings is potentially huge.
### ED Appropriate Utilization (Standalone Measure)

| Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Process Milestone 2 [P-3]: Develop and test data systems.  
Data Source: Results of systems tests in IT development environment and registry functionality in production environment. | Outcome Improvement Target 1 [IT-9.2]: Reduce Emergency Department visits for adult and pediatric asthma registry patients assigned to three target clinics  
Improvement Target: TBD  
Data Source: EMR and claims | Outcome Improvement Target 2 [IT-9.2]: Reduce Emergency Department visits for adult and pediatric asthma registry patients assigned to three target clinics  
Improvement Target: TBD  
Data Source: Registry and EMR |
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<tbody>
<tr>
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<td>Year 2 Estimated Outcome Amount: $554,784</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,697,328
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-2.8 Diabetes Long Term Complications Admission Rate-PQI3 (Standalone measure)</th>
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</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number: 136141205.3.6 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: University Hospital</td>
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<tr>
<td>TPI: 136141205</td>
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</tbody>
</table>

### Outcome Measure Description:

**IT- IT-2.8 Diabetes Long Term Complications Admission Rate-PQI3**

- **Numerator:** discharges age 18 years and older with a principal diagnosis code for long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified.
- **Denominator:** Population in Metro Area or county, age 18 years and older.
- **Data Source:** EHR, Claims

### Process Milestones:

**DY2:**

Process Milestone 1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans, relates directly to the milestones outlined in the Health System’s Category 1 Table for 136141205.1.4 This will be an expansion and enhancement program. The Health System is already a partner in employing telemedicine in the Bexar County Adult Detention Center, reaching a population that is both literally and figurative difficult to reach. The experience gives us confidence that enhancing and expanding this capability to our current clinic patient population and in partnership with the other performing providers in RHP6 will vastly improve management of diabetes. The IS Chief Medical Information officer will be the project lead and, using the Health System’s established Project Charter process, create the plan.

**DY3:**

Process Milestone 2: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Process Milestone 2 affords the opportunity to engage in quality improvements, share lessons learned, and effect rapid cycle improvements as appropriate.

### Outcome Improvement Targets:

Category 3 Outcome: Diabetes Long Term Complications Admission Rate-PQI3 populates both DYs 4 and 5 in anticipation of continuous improvement. The outcome improvement targets are yet to be determined (TBD) for DYs 4 and 5.

### Rationale:

Process Milestone 1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. As noted above, the Health System currently employs telemedicine on a pilot basis for the Bexar County Adult Detention Center inmates. Expanding the technology to patient clinic sites, as well as to regional partners in the future, however, requires a completely new planning process.

Process Milestone 2: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and
intervention activities. As mentioned, Process Milestone 2 affords the opportunity to engage in quality improvements, share lessons learned, and effect rapid cycle improvements as appropriate. This milestone is the natural extension to creation of the project plan as the steps to implementation are completed.

The outcome improvement targets for the selected Category 3 Outcome, “Diabetes Long Term Complications Admission Rate-PQI3,” in both DY 4 and 5, will be determined in DY 2 for implementation in DY 3. This outcome improvement measure was chosen for its direct relation to the goals of the Waiver by a) improve the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further develop and maintain a coordinated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce hospital admissions (containing cost growth).

**Outcome Measure Valuation:**

Success of the telemedicine program in the form of reduced preventable hospital admissions for adults with diabetes will be an indicator for achievement of Waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth). When fully implemented – beyond DY5 – which includes telemedicine initiatives for other highly prevalent chronic conditions, such as CHF, as well as eventually sharing the technology among the region’s Performing Providers, the larger scope of the project should impact proper utilization in the form of increased routine and follow-up patient visits and encounters and reduced preventable hospital admissions.

This project requires investment as it complements HITECH funding goals. The hardware, software applications, human resources, and time to implement are of the highest organizational priority for the Health System. This particular project targets diabetes, but the scope of utilization for other chronic diseases and in other health care settings is potentially huge.
**136141205.3.6**  
PASS 1  

<table>
<thead>
<tr>
<th>3-IT-2.8</th>
<th>Diabetes Long Term Complications Admission Rate-PQI3</th>
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<tr>
<th>Starting Point/Baseline:</th>
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</table>

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|--------------------------|--------------------------|--------------------------|--------------------------|

**Process Milestone 1**  
[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Needs assessment and project planning documentation.

**Process Milestone 1 Estimated Incentive Payment:** $471,566

**Process Milestone 2**  
[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
Data Source: EMR, patient appointment records, and medication compliance information

**Process Milestone 2 Estimated Incentive Payment:** $546,607

**Outcome Improvement Target 1**  
[IT-2.8]: Reduce Diabetes Long Term Complications Admission Rate-PQI3  
Improvement Target: TBD  
Data Source: EMR, claims data

**Outcome Improvement Target 1 Estimated Incentive Payment:** $877,113

**Outcome Improvement Target 2**  
[IT-2.8]: Reduce Diabetes Long Term Complications Admission Rate-PQI3  
Improvement Target: TBD  
Data Source: EMR, claims data

**Outcome Improvement Target 2 Estimated Incentive Payment:** $2,097,443

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<tr>
<th>Year 2 Estimated Outcome Amount: $471,566</th>
<th>Year 3 Estimated Outcome Amount: $546,607</th>
<th>Year 4 Estimated Outcome Amount: $877,113</th>
<th>Year 5 Estimated Outcome Amount: $2,097,443</th>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** $ 3,992,729
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576 (Standalone measure).
Unique RHP outcome identification number: 136141205.3.7 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

**IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)**

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

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

b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

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

c. Data Source: EHR, Claims

d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

Rate 1. The percentage of members who received follow-up within 30 days of discharge
Rate 2. The percentage of members who received follow-up within 7 days of discharge.

Process Milestones

- **DY2- Process Milestone P-2: Establish baseline rates.** Collaborate with Information Technology Services to determine means by which the following are defined:
  Numerator- number of patients 6 years and older discharged from University Hospital inpatient settings with certain principle behavioral health diagnoses within the project population securing follow-up appointments with a mental health practitioner in University Hospital.
Health System outpatient medical homes within the specified time frame (Rate 1: Percentage of members who received follow-up within 30 days of discharge; Rate 2: Percentage of members who received follow-up within 7 days of discharge). 

**Denominator:** all patients 6 years or older who receive primary care in University Health System Medical Homes who are discharged from inpatient settings in University Hospital with certain principle behavioral health diagnoses.

Note - Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for mental health principal diagnosis (within the 30-day follow-up period), count only the readmission discharge or the discharge from the facility to which the member was transferred.

- **DY3- Process Milestone P-3: Develop and test data systems.** Assess all processes and procedures related to securing outpatient appointments with mental health practitioners following discharge from inpatient settings for the project population. Include all stakeholders, (inpatient and outpatient), and include evaluation of barriers faced. Refine the diagnostic codes as necessary to determine behavioral health diagnoses in the discharged population. Develop a written protocol for the defined population to include EMR documentation related to discharge planning and process for securing outpatient follow-up appointments. Vet with all stakeholders.

**Outcome Improvement Milestones for each year:**

- **DY4-** Increase IT-1.18 Follow-Up After Hospitalization for Mental Illness by TBD over baseline year those securing outpatient mental health practitioner appointments within 7 days and 30 days after discharge for the project targeted population.

- **DY5-** Increase IT-1.18 Follow-Up After Hospitalization for Mental Illness by TBD over baseline year those securing outpatient mental health practitioner appointments within 7 days and 30 days after discharge for the project targeted population.

**Rationale:**
The rationale for selecting the process milestones reflect the methodical approach that will be undertaken to engage stakeholder, identify needed resources, develop an implementation and project monitoring plan to ensure an appropriate alignment with improving and reporting on patient satisfaction.

**In DY 2 and DY 3 process milestones will be addressed as follows:**

Outpatient follow-up with specialty behavioral health practitioners after discharged from the hospital allows for maintenance of stability of mental illness, continued assessment of need for support services, encouragement of compliance with treatment, and engagement in a system of care outside the hospital setting. The time period shortly after release form the hospital tends to be a high risk time for decompensation if timely follow-up is not provided. Cost avoidance relates to potentially avoided
readmission and ER visits. Having outpatient psychiatric care within the medical home/neighborhood clinics supports engagement of the patient in treatment for mental health and physical health needs in one setting.

This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who have an outpatient encounter with a mental health practitioner within 7 days and 30 days of discharge from the hospital.

**Outcome Measure Valuation:**

Outcome measure valuation for *follow-up after hospitalization for mental illness* by directly responding to waiver goals including the triple aim and improving the health delivery infrastructure to better serve the Medicaid and uninsured residents of the community and region. This includes providing care in the right setting at the right time and enhancing the ability to treat mental health disorders earlier in the course of illness, both of which may contribute to avoidance of unnecessary admissions and ER visits that might be due to untreated mental illness.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong> Establish baseline rates for percentage of members who 1) received follow-up within 30 days of discharge and 2) who received follow-up within 7 days of discharge.</td>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems for processes and procedures related to securing outpatient appointments following discharge from inpatient visit</td>
<td><strong>Outcome Improvement Target 1 [IT-1.18]:</strong> Increase percent of patients with outpatient follow-up at 7 and 30 days post hospital discharge by X% from baseline DY2. (TBD)</td>
<td><strong>Outcome Improvement Target 2 [IT-1.18]:</strong> Increase percent of patients with outpatient follow-up at 7 and 30 days post hospital discharge by X% from baseline DY2. (TBD)</td>
</tr>
<tr>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
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<td>Outcome Improvement Target 2 Estimated Incentive Payment: $2,467,580</td>
</tr>
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<td>Year 2 Estimated Outcome Amount: $554,784</td>
<td>Year 3 Estimated Outcome Amount: $643,067</td>
<td>Year 4 Estimated Outcome Amount: $1,031,897</td>
<td>Year 5 Estimated Outcome Amount: $2,467,580</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,697,328**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT – 12.5 Other USPSTF-endorsed screening outcome measures (Screening for obesity in children and adolescents) |
| Unique RHP outcome identification number: 136141205.3.8– PASS 1 |
| Performing Provider: University Hospital |
| TPI: 136141205 |

**Outcome Measure Description:**

Outcome Measure Description:

IT – 12.5 Other USPSTF-endorsed screening outcome measures *(Screening for obesity in children and adolescents)*

This measure includes:

**Numerator:** Number of children ages 6 years and older screened and referred to comprehensive behavioral interventions to promote weight status.

**Denominator:** Number of children ages 6 and older from the target population.

**Data Source:** EHR, Claims

The process measurements selected are: P-1 Project Planning and P-2 Establish Baseline Rates.

**Process Milestones:**

**DY2:**

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**DY3:**

P-2: Establish Baseline Rates for screening for obesity in children and adolescents

**Outcome Improvement Targets for each year:**

This outcome improvement measure was chosen for its direct relationship to the goals of the Waiver by a) improve the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further develop and maintain a coordinated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

**DY4:**

IT-12.5: TBD Percent improvement over baseline of number of children and adolescents screened for obesity

**DY5:**

IT-12.5: TBD Percent improvement over baseline of number of children and adolescents screened for obesity

**Rationale:**

Since the 1970s, childhood and adolescent obesity has increased three- to six fold. Approximately
12% to 18% of 2 to 19-year-old children and adolescents are obese (defined as having an age and gender-specific BMI at ≥95th percentile). The US Preventive Services Task Force (USPSTF) recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. The USPSTF found that effective comprehensive weight-management programs incorporated counseling and other interventions that targeted diet and physical activity. Interventions also included behavioral management techniques to assist in behavior change. Interventions that focused on younger children incorporated parental involvement as a component.

In Bexar County, Texas it is estimated that 23% of children on WIC are either overweight or obese. As in adults, individuals who are in these clinical categories are more likely to be at risk for Type 2 diabetes, asthma, high blood pressure.

Expanding primary care and prevention and establishing a usual source of care for this population can strengthen healthy behaviors and early adoption to adhere to regular clinical preventive care.

Our goal is by DY 4 and DY 5 to increase access to clinical preventive care over baseline by implementing screening practices that identify children and adolescents who are obese who are then referred into evidence-based health service interventions encouraging physical activity, healthy eating and adherence to good clinical preventive care. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare UHS to report outcomes in DY4 and DY5.

The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

To ensure that project performance milestones are met an evaluation plan will be developed and implemented to monitor project activities. The evaluation is based on elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. Use of this framework ensures barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus on specific components of the intervention, clearly identifying the target population, setting obtainable targets, and effectively maintaining program fidelity through a focused and rigorous research design (Glasgow & Emmons, 2007).
**Outcome Measure Valuation:**

Adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability and are in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from the flu to cancer and that if caught in their earlier, more treatable stages, can significantly reducing the risk of illness, disability, early death, and health care costs. For example, on average, 42,000 deaths per year are prevented among children who receive recommended childhood vaccines. Yet, despite this evidence and such services are now covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act (ACA), large segments of the U.S. population which translate into millions of children, adolescents, and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
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<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>P-1 Project Planning</td>
<td>P-2 Establish Baseline Rates</td>
<td>IT-12.5 Other USPSTF-endorsed screening outcome measures (Screening for obesity in children and adolescents)</td>
<td>IT-12.5 Other USPSTF-endorsed screening outcome measures (Screening for obesity in children and adolescents)</td>
</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Percent improvement over baseline of number of children and adolescents screened for obesity Goal: Increase number of screens.</td>
<td>Improvement Target: Percent improvement over baseline of number of children and adolescents screened for obesity Goal: Increase number of screens.</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $157,189</td>
<td>Year 3 Estimated Outcome Amount: $182,202</td>
<td>Year 4 Estimated Outcome Amount: $292,371</td>
<td>Year 5 Estimated Outcome Amount: $699,148</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 1,330,910**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT – 12.5 Other USPSTF-endorsed screening outcome measures (screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

Unique RHP outcome identification number(s): 136141205.3.9 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT – 12.5 Other USPSTF-endorsed screening outcome measures screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

This measure includes:

Numerator: Number of adolescents ages 12 to 18 years screened for major depressive disorder.

Denominator: Number of adolescents ages 12 to 18 from the target population.

Data Source: EHR, Claims

The process measurements selected are: P-1 Project Planning and P-2 Establish Baseline Rates.

Process Milestones:

DY2:
P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

DY3:
P-2: Establish Baseline Rates for screening for obesity in children and adolescents

Outcome Improvement Targets for each year:

This outcome improvement measure was chosen for its direct relation to the goals of the Waiver by a) improve the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further develop and maintain a coordinated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

DY4:
IT-12.5: Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)

DY5:
IT-12.5: Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)
### Rationale:

Depression among youth is a relatively common, disabling condition that is associated with serious long-term morbidities and risk of suicide. The majority of depressed youth, however, are undiagnosed and untreated, despite opportunities for identification in settings such as primary care. A synthesis of the evidence suggest that primary care screening tools may be accurate in identifying depressed adolescents, and treatment can improve depression outcomes. Specific treatment should be based on the individual's needs and mental health treatment guidelines (USPSTF, Systematic Review, 2009).

Expanding primary/pediatric primary care and prevention and establishing a usual source of care for this population can strengthen healthy behaviors and early adoption to adhere to regular clinical preventive care that includes screening and immunizations.

The goal of this project is by DY 4 and DY 5 to increase access to clinical preventive care by TBD\% over baseline by implementing clinical practice guidelines that screen adolescents 12-18 years of age for major depressive disorders. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare UHS to report outcomes in DY4 and DY5.

The two process milestones selected are:

**P-1: Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**P-2: Establish Baseline Rates**

To ensure that project performance milestones are met an evaluation plan will be developed and implemented to monitor project activities. The evaluation is passed on elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. Use of this framework ensures barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus on specific components of the intervention, clearly identifying the target population, setting obtainable targets, and effectively maintaining program fidelity through a focused and rigorous research design (Glasgow & Emmons, 2007).
Outcome Measure Valuation:

Adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability is in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from screening for depression, flu to cancer that if diagnosed earlier, and in more treatable stages, can significantly reducing the risk of illness, disability, early death, and health care costs. Yet, despite this evidence and such services are now covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act (ACA), large segments of the U.S. population which translate into millions of children, adolescents, and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>136141205.3.9</th>
<th>3.IT-12.5</th>
<th>Other USPSTF-endorsed screening outcome measures screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up</th>
</tr>
</thead>
</table>

**University Hospital**

**TPI- 136141205**

**Starting Point/Baseline:**

- **To be developed in DY3**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<td>Process Milestone 1</td>
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<td>P-1 Project Planning</td>
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</tr>
<tr>
<td>Data Source: Planning Document</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)</td>
<td>Improvement Target: Percent improvement over baseline of number of adolescents screened for major depressive disorder (MDD)</td>
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</tr>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 1,330,910**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT – 12.5 Other USPSTF-endorsed screening outcome measures: Immunizations, Adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) using American Academy of Family Physicians (AAFP) recommendations unless contraindicated

Unique RHP outcome identification number(s): 136141205.3.10 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT – 12.5 Other USPSTF-endorsed screening outcome measures **Immunizations, Adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) using American Academy of Family Physicians (AAFP) recommendations unless contraindicated**

This measure includes:

**Numerator:** Number of adolescents ages 13 to 18 years that receive the meningococcal conjugate vaccine (MCV-1).

**Denominator:** Number of adolescents ages 13 to 18 from the target population.

**Data Source:** EHR, Claims

The process measurements selected are: P-1 Project Planning and P-2 Establish Baseline Rates.

**Process Milestones:**

**DY2:**
P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**DY3:**
P-2: Establish Baseline Rates for number of adolescents ages 13 to 18 years that receive the meningococcal conjugate vaccine (MCV-1).

**Outcome Improvement Targets for each year:**

This outcome improvement measure was chosen for its direct relationship to the goals of the Waiver by a) improve the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further develop and maintain a coordinated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

**DY4:**
IT-12.5: TBD Percent improvement over baseline of number of adolescents 13-18 that receive the Meningococcal Conjugate Vaccine (MCV-1)

**DY5:**
IT-12.5: TBD Percent improvement over baseline of number of adolescents 13-18 that receive...
the Meningococcal Conjugate Vaccine (MCV-1)

**Rationale:**

Adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability and are in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from the flu to cancer and that if caught in their earlier, more treatable stages, can significantly reduce the risk of illness, disability, early death, and health care costs. For example, on average, 42,000 deaths per year are prevented among children who receive recommended childhood vaccines.

Our goal is by **DY 4 and DY 5** to increase access to clinical preventive care over baseline by implementing screening and immunization practices that identify children and adolescents in need of the Meningococcal Conjugate Vaccine (MCV-1) ages 13 through 18 years if not previously vaccinated. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare UHS to report outcomes in DY4 and DY5.

The two process milestones selected are:

**P-1:** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**P-2:** Establish Baseline Rates

To ensure that project performance milestones are met an evaluation plan will be developed and implemented to monitor project activities. The evaluation is based on elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. Use of this framework ensures barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus on specific components of the intervention, clearly identifying the target population, setting obtainable targets, and effectively maintaining program fidelity through a focused and rigorous research design (Glasgow & Emmons, 2007).
<table>
<thead>
<tr>
<th><strong>Outcome Measure Valuation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability is in line with national health goals. There is clear evidence that clinical preventive services can both prevent and detect illnesses and disease that range from screening for depression, flu to cancer and that if diagnosed earlier, and in more treatable stages, can significantly reducing the risk of illness, disability, early death, and health care costs. Yet, despite this evidence and such services are now covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act (ACA), large segments of the U.S. population which translate into millions of children, adolescents, and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects::</td>
</tr>
<tr>
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Starting Point/Baseline: 
*To be developed in DY3*

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1</strong> P-1 Project Planning</td>
<td><strong>Process Milestone 2</strong> P-2 Establish Baseline Rates</td>
<td><strong>Outcome Improvement Target 1</strong> IT-12.5 Other USPSTF-endorsed screening outcome measures: Immunizations, Adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) ** Improvement Target: TBD ** Percent improvement over baseline of number of adolescents 13-18 that receive the Meningococcal Conjugate Vaccine (MCV-1) ** Goal: Increase number of vaccinations. ** Data Source: Electronic Health Record</td>
<td><strong>Outcome Improvement Target 2</strong> IT-12.5 Other USPSTF-endorsed screening outcome measures: Immunizations, Adolescents 13-18 years of the Meningococcal Conjugate Vaccine (MCV-1) ** Improvement Target: TBD ** Percent improvement over baseline of number of adolescents 13-18 that receive the Meningococcal Conjugate Vaccine (MCV-1) ** Goal: Increase number of vaccinations. ** Data Source: Electronic Health Record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $292,371</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $699,148</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: 1,330,910**
Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-2.13 Other Admission Rate (Stand-alone measure): Admission rate of patients managed by TOC project</th>
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<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>136141205.3.11 – PASS 1</td>
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<tr>
<td>Performing Provider:</td>
<td>University Hospital</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>136141205</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

**OD-2 Potentially Preventable Admissions**

- **IT-2.13 Other Admission Rate (Stand-alone measure): Admission rate of patients managed by TOC project**
  - **Numerator:** Readmitted patients managed by TOC project
  - **Denominator:** All readmitted patients to University Health System within 30 days
  - **Data Source:** EMR/IDX/Crimson/Truven Health/Allscripts

**Process Milestone**

**DY2**

- **P-2: Establish baseline rates**
  - Early November 2012, a LEAN event has been scheduled to evaluate and assess the Transitions of Care Program by coordinating a priorities session. The intent of the week long event will be to establish where the efforts of the Transitions of Care Implementation Team need to focus their attention. The outcome will be a roadmap to the development of a Transitions of Care Program targeting the delivery of care post discharge and incorporating education, specialty visits, post discharge phone calls, medication reconciliation, and much more.

**DY3**

- **P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.**
  - Once the program is defined and the tasks are prioritized by level of significance as well as achievable goals, the next step will to identify the stakeholders and engage the individuals identified. The approach will be two fold:
    - **First,** an Executive Team will be established for reporting of efforts. An initial meeting will be held to identify the results of the LEAN event and identify the teams implemented as a result of the prioritization session.
    - **Second,** will be the identification of the implementation team members and the subcommittees needed to accomplish the goals and priorities established.

**Outcome Improvement Target**

**DY4/5**

- **IT-2.13 Other Admissions Rate (Stand-Alone Measure): Admission rate of patients managed by TOC project**
  - As the project continues to work towards reducing admissions, the Outcome Improvement Target will be reducing rates of readmission for patients identified
and managed by the Transitions of Care Project. The 5 year goal will be for 65% of patients identified as high risk and, thus, managed within the Transitions of Care program will not be readmitted.

**Rationale:**

It is vital for University Health System to target the discharge process and the first 48 hours and days post discharge because that is the most vulnerable time once a patient has returned home to struggle and return to the hospital and/or EC. The project will “significantly enhance” pre-existing efforts as stated per the baseline above. Although the work was thorough and fruitful, the following gaps remain:

- how to better identify patients at high risk before discharge and at home
- education at discharge and via post discharge calls
- referral processes
- improved internal and external handoffs and communication, and
- patient engagement.

**Outcome Measure Valuation:**

Project valuation for an efficient and comprehensive Patient Care Transition Program is prioritized as a Pass 1. As there are approximately 22,000 or more discharges a year, around 55,000 EC visits, and > 580,000 Ambulatory visits expected in 2013, better transitions of care impact is defined through cost avoidance, a reduction of admissions and readmissions as well as a decreased EC utilization.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TPI - 136141205</td>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Outcome Improvement Target 1 [IT-2.13]: Other Admission Rate: Admission rate of patients managed by TOC project</td>
<td>Outcome Improvement Target 2 [IT-2.13]: Other Admission Rate: Admission rate of patients managed by TOC project</td>
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<tr>
<td>Data Source: LEAN Event Report</td>
<td>Data Source: Meeting minutes</td>
<td>Improvement Target: TBD</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $443,827</td>
<td>Process Milestone 2 Estimated Incentive Payment: $514,453</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $825,518</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,974,065</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $443,827</td>
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</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,757,863
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP ID#: 136141205.3.12 – PASS 1
Performing Provider: University Hospital
Performing Provider TPI: 136141205

Outcome Measure Description:
OD-6 Patient Satisfaction/ IT 6.1

- IT-6.1 Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAPHS survey may be used to establish if patients: are getting timely care, appointments, and information; how well their doctors communicate; patient’s rating of doctor access to specialist; patient’s involvement in shared decision making, and patient’s overall health status/functional status.

Process Milestone
DY2

- P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.
  - DY2 will be used for reviewing and developing a strategic plan and training programs specific to Patient Centered Care
  - A patient/family experience strategic plan (to include plans for implementation of this plan) will be written by the Executive Director of Patient Centered Care and reviewed and approved by executive leadership of the health system to include both inpatient and outpatient services.
  - Working with Human Resources and Learning Resources Departments a training program specifically aimed at understanding Patient-Centered Care approach will be established.

DY3

- P-2 Establish baseline rates
  - Once the plans are written, disseminated and training is reviewed and agreed upon by the stake-holders we will be able to determine the amount of training necessary to ensure staff are in complete understanding of patient-centered care and focused on being a patient centered organization.

Rationale:

P-1 was selected as the process metric because is extremely important that stakeholders are engaged and on-board both with reviewing the material needed as well as training all University Health System staff members in the new philosophy of patient centered care. Timelines will be crucial in this endeavor as the focus on customer service and patient centered care tends to be moved down the list of priorities and it is crucial that it remains a top
**Outcome Measure Valuation:**

The outcome measure for this project is a 2% improvement in patient satisfaction scores for DY4 and 5 as illustrated in milestones 6 and 7. Improved patient satisfaction with health care services is a direct measure of how well we are accomplishing our triple aim goals of better health, better healthcare, and reduced cost. Satisfaction scores also support process improvement efforts to help identify areas that are in need of attention. University Health System is focused on reaching (NRC average) 25%. 2% improvement in DY 4 and DY 5 will ensure we are achieving the set goal.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
</table>
| [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. | [P-2]: Establish baseline rates  
Data Source: NRC Picker | [IT-6.1] Percent improvement over baseline of patient satisfaction scores by 2%  
- Getting timely care, appointments, and information.  
- Data Source: NRC Picker comments and anecdotal findings through telephone calls or letters. | [IT-6.1] Percent improvement over DY4 patient satisfaction scores by 2%  
- Patient’s rating of doctor access to specialist.  
- Data Source: NRC Picker comments and anecdotal findings through telephone calls or letters. |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
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<td>136141205.2.2</td>
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<td>Starting Point/Baseline:</td>
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<tr>
<td>Data Source: Meeting minutes and final plan</td>
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<tr>
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<td>Year 4 Estimated Outcome Amount: $1,031,896</td>
<td>Year 5 Estimated Outcome Amount: $2,467,581</td>
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TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,697,328
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT – 5.1 Improved cost savings: demonstrate cost savings in care delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Identification Number: 136141205.3.13 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: University Hospital</td>
</tr>
<tr>
<td>TPI: 136141205</td>
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</table>

**Outcome Measure Description:**

<table>
<thead>
<tr>
<th>OD – 5 Cost of Care (non-stand alone)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Measures</strong></td>
</tr>
<tr>
<td>P – 1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
</tr>
<tr>
<td>P – 2 Establish baseline rates.</td>
</tr>
<tr>
<td>P – 3 Develop and test data systems</td>
</tr>
</tbody>
</table>

**Improvement Measure:**

<table>
<thead>
<tr>
<th>IT – 5.1 Improved cost savings: demonstrate cost savings in care delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Type of analysis to be determined by the provider: cost minimization</td>
</tr>
<tr>
<td>b. Data source: EPSI Budget System</td>
</tr>
</tbody>
</table>

**Rationale:**

**P – 1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**

University Health System would need to coordinate this effort by pulling in leadership of the participating clinical departments and nursing units to raise awareness on the importance of driving down cost in the system. Stakeholders would design protocols and reporting tools to monitor performance against the project timeline based on the process improvement projects deadlines.

**P – 2: Establish baseline rates**

Part of the problem is identifying where the baseline is. EPSI (University Health System’s new budgeting system) will provide this data.

**P – 3: Develop and test data systems**

Configuration of EPSI will be required to pull correct, consistent cost data.

**IT – 5.1: Improved cost savings: demonstrate cost savings in care deliver**

Lean process improvement initiative will streamline processes. Part of reducing waste includes cost minimization because fewer resources are being devoted towards ‘non-value added’ activities. University Health System expects to see a decrease in the cost of care delivery as Lean management philosophies are developed throughout the system.

**Outcome Measure Valuation:**

The process milestones represent the build up to reaching the improvement target. Essentially, cost minimization adds value to the tax-paying citizens of Bexar county. As the county hospital, University Health System has a fiscal responsibility to use the resources given by the county as efficiently as possible. Lean process improvement focuses on reducing waste, one of which is unnecessary cost. P – 1 helps outline the departments or processes for cost minimization. The next step is measuring success which requires a baseline from which to gauge that success, P – 2. Ensuring consistency of our data systems will also go into this planning phase, P – 3.
<table>
<thead>
<tr>
<th>136141205.3.13 PASS 1</th>
<th>3.IT-5.1</th>
<th>Improved Cost Savings: Demonstrate Cost Savings in Care Delivery</th>
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<tbody>
<tr>
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<td>TPI - 136141205</td>
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<tr>
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<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>To be developed in DY2</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 3</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>P-1 [Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans]</td>
<td>P-3 [Develop and test data systems]</td>
<td>[IT-5.1]: TBD</td>
</tr>
<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: EPSI budgeting system</td>
<td>Improvement Target: Improved cost savings: demonstrate cost savings in care delivery by TBD% from baseline</td>
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<tr>
<td><strong>Process Milestone 2</strong></td>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $515,949</td>
</tr>
<tr>
<td>P-2 [Establish baselines]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EPSI budgeting system</td>
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<td></td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $138,696</td>
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<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $277,392</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $321,534</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $515,949</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,348,666**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT.6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)
Unique RHP Identification Number: 136141205.3.14 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
1. are getting timely care, appointments, and information; (Standalone measure)
2. how well their doctors communicate; (Standalone measure)
3. patient’s rating of doctor access to specialist; (Standalone measure)
4. patient’s involvement in shared decision making, and (Standalone measure)
5. patient’s overall health status/functional status. (Standalone measure)
a Numerator: Percent improvement in targeted patient satisfaction domain
b Data Source: Patient survey
c Denominator: Number of patients who were administered the survey

Process Milestones
- DY2
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.
- DY3
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders.

Improvement Targets
- DY4
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores
- DY5
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores

Rationale:
The rationale for selecting the following process milestones reflect the methodical approach that will be undertaken to engage stakeholder, identify needed resources, develop an implementation and project monitoring plan to ensure an appropriate alignment with improving and reporting on patient satisfaction.

In DY 2 and DY 3 process milestones will be addressed as follows:

P – 1: Project planning
University Health System would need to coordinate this effort by pulling in leadership of participating departments and clinical units to raise awareness on the importance of improving
patient satisfaction. Stakeholders would design protocols and reporting tools to monitor performance against the project timeline.

P – 5: Disseminate findings, including lessons learned and best practices, to stakeholders
After DY2, stakeholders would communicate successes and shortcomings or other insight learned from the project initiatives.

Improvement target for DY 4 and DY 5 were chosen to based on implementation timeline of the Lean process improvement initiative which will streamline processes around the patient’s experience. Reducing waste and focusing on the ‘value added’ activities will increase satisfaction. Workflows and throughput process will be designed to get the patient through the system as efficiently as possible. Clinicians can spend more time focused on patient care and patients will spend less time waiting for staff to work through inefficient processes. University Health System expects to see an increase in the patient satisfaction of care delivery as Lean management philosophies are developed throughout the system.

Outcome Measure Valuation:
The value and success of this category 3 outcome will based on improvement of HCAHPS patient satisfaction scores. Process improvements will focus on improving the overall experience for all patients within UH by driving out waste and focusing on the ‘value-added’ activities. This project is directly related to CN.1 as RHP 6 is challenged to increase patient satisfaction.
<table>
<thead>
<tr>
<th>136141205.3.14 PASS 1</th>
<th>3.IT-6.1</th>
<th>Percent Improvement Over Baseline of Patient Satisfaction Scores</th>
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<tbody>
<tr>
<td><strong>University Hospital</strong></td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
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<td>To be developed in DY3</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> P-1 [Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Data Source: Meeting minutes</td>
<td><strong>Process Milestone 2</strong> P-5 [Disseminate findings, including lessons learned and best practices, to stakeholders] Data Source: Meeting minutes/report outs Process Milestone 2 Estimated Incentive Payment: $321,534</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-6.1]: Percent improvement over baseline of patient satisfaction scores: TBD Data Source: Patient satisfaction survey Outcome Improvement Target 1 Estimated Incentive Payment: $515,949</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $277,392</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $277,392</td>
<td>Year 3 Estimated Outcome Amount: $321,534</td>
<td>Year 4 Estimated Outcome Amount: $515,949</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,358,666
Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization |
| Unique RHP ID#: 136141205.3.15 – PASS 1 |
| Performing Provider: University Hospital |
| Performing Provider TPI: 136141205 |

Outcome Measure Description:

OD-9 Right Care, Right Setting

- IT-9.2 ED appropriate utilization (Stand-alone measure)
  - Reduce Emergency Department visits for targeted conditions
  - Data Source: EMR/IDX/Crimson/Truven Health/Allscripts

Process Milestone

DY2

- P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.
  - DY2 will be the year used to continuously identify the appropriate personnel assigned to a Navigation/Care coordination Program, to engage those identified individuals, to determine the resources needed for a successful implementation and expansion, as well as the development of an implementation plan.
  - Preliminary stakeholders include executive leadership from ambulatory and acute providers, other clinic personnel, and ED personnel.
  - Identified stakeholders will be actively engaged through regular meetings. The meetings will be an opportunity to show successes and discuss opportunities for improvement.

- P-2 Establish baseline rates
  - Once the implementation plan is established and vetted with appropriate members of the organization, the Navigation Program will begin to review all data associated with ED visits to determine the population of most needed support. The data will be used to identify the population with frequent EC visits and misuse.

Outcome Improvement Target

DY4/5

- IT-9.2 ED appropriate utilization (Stand-alone measure)
  - The selection of Outcome Improvement Target 9.2 was based on the long term goal of the Navigation Program of reducing EC utilization. The goal of the project is to reduce EC utilization for a defined population with chronic medical conditions and patients identified as high utilizers.
  - The Outcome Improvement Target allows University Health System to assess pre and post navigation services for identified patients. Target will be determined following baseline measure.
**Rationale:**

P-1 was selected as the process metric for University Health System because to date case managers, social workers and other personnel have only recently begun or introduced in the ED and in Ambulatory settings to assist with navigation and care coordination. Though ED visits were up 2.6% in 2012 from 2011, there is a population identified as high utilizers who frequent the ED for any number of health care and behavioral reasons and who would benefit from better access and coordination in the community. University Health System will develop a comprehensive implementation plan with plans to increase staffing in 2013 into additional Ambulatory settings. Metrics of success and stakeholder buy-in continues to evolve. ED utilization is a targeted metric for improvement. Baseline data will be gathered once staff and full implementation occurs per clinic setting for improved community access.

The Improvement target was chosen based on previous research that showed similar programs being able to impact ED utilization.

**Outcome Measure Valuation:**

Via the system created to weight all University Health System projects, this project was rated very high (18) due to the anticipated volume of patients touched who will receive case management and social services support. Cost avoidance is the anticipated end result secondary to a reduction of admissions and readmissions as well as a decrease in ED utilization. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
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<thead>
<tr>
<th>136141205.3.15</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization</th>
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<tr>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-9.2] ED appropriate utilization (Stand-alone measure)</td>
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<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: IDX/Truven Health/Crimson</td>
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<td>Year 4 Estimated Outcome Amount: $928,708</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,227,595
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Unique RHP ID#: 136141205.3.16 – PASS 1
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

Process milestones:
During **DY2**, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will specifically engage in Project Planning (P-1) for process improvement. This will include engaging multiple stakeholders, identification of current capacity and needed resources, determination of specific timelines and documentation and implementation of plans to address the outcome improvement measures for palliative care patients.

During **DY3**, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will use information gathered and systems developed during DY2 to establish baseline rates (P-2) for the outcome improvement measures for palliative care patients.

Outcome improvement measures:
Percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

**Numerator**: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.

**Denominator**: Patients receiving palliative care who report pain when pain screening is done on the admission evaluation/initial encounter.

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

**Data Source**: EHR, Palliative Care Database

**DY4**: Of patients receiving palliative care who report pain when pain screening is done on the admission evaluation/initial encounter, the palliative care team will successfully provide a comprehensive clinical assessment to determine the severity, etiology and impact of pain within 24 hours of screening positive for pain to at least 75% of patients(479).

**DY5**: Of patients receiving palliative care who report pain when pain screening is done on the admission evaluation/initial encounter, the palliative care team will successfully provide a comprehensive clinical assessment to determine the severity, etiology and impact of pain within 24 hours of screening positive for pain to at least 90% of patients(574).

Rationale:

The process metrics chosen are an essential to develop a systematic process for the quality improvement cycle related to fostering successful outcomes anticipated in DY4 and DY5. For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, treatment preferences, and documentation of spiritual concerns) reflect some of the core quality measures needed to achieve excellence in patient care. These metrics also correlate with the selected Process and Improvement metrics. Patients report problems with hospital symptom management and continuity of care:

- 1 in 2 patients describe their hospital care as “suboptimal”⁹⁴

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• 1 in 4 patients report inadequate treatment for pain and shortness of breath\textsuperscript{95}
• 1 in 3 families report inadequate emotional support\textsuperscript{96}
• 1 in 3 patients state they are poorly educated for pain and other symptom management after hospital discharge\textsuperscript{97}
• 1 in 3 patients are not provided plans for follow-care after hospital discharge.\textsuperscript{98}
• Over 50% of deaths in America occur in the hospital setting.\textsuperscript{99}
• Over 70% of patients who die in the hospital were admitted to the hospital in the previous 6 months.\textsuperscript{100}
• Only 40% of public hospitals have access to Palliative Care specialists.\textsuperscript{101}
• About 33% of patients enrolled in hospice die within one week.\textsuperscript{102}

Improving access to LIFE Care/Palliative Medicine services involves implementation of a comprehensive supportive service that inevitably relies on changing the culture in which the service is practiced. Referring physicians and physicians-in-training need to understand and appreciate the role that Palliative Care can play in improving patient and family satisfaction, pain and other symptom management, and in promoting patient and family-centered care. Education of referring physicians, especially primary care physicians and physicians-in-training, can deepen the appreciation for supportive care. Education in Palliative Care can also promote best practices and broad patient access to competent delivery of basics in Palliative Care, such as the safe use of opioids, emotional and spiritual aspects of care, and ethical issues related to surrogate decision-making and withdrawing or withholding life-sustaining interventions.

**Outcome Measure Valuation:**

For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, life sustaining treatment preferences, and documentation of spiritual concerns) are valued based on their ability to demonstrate tangible achievement with various elements of a successful palliative care program and their impact on patient comfort, safety, and health care outcomes. One first step towards controlling pain and improving patient outcomes is to maximize and standardize the assessment and to anticipate the pain of our highest risk patients, especially those undergoing surgery or invasive procedures and those with advanced illness such as metastatic cancer. A consensus statement from an "International Expert Panel" out of Johns Hopkins in 2008 stated that opioids are an essential part of patient care for the elderly and patients with cancer.\textsuperscript{103} They recommended the use of evidenced-based medicine to establish local clinical practice guidelines for clinicians who prescribe opioids. They argue that increased awareness of medication profiles can promote effective and safe pain relief. Both the Agency for Health Care Research and the American Pain Society recommend balancing effective analgesia with effective monitoring, prevention, and management of adverse opioid events. The Category 3 metrics for this project will establish a systematic process to achieve higher standard for pain

\textsuperscript{96}Ibid.
\textsuperscript{98}Ibid.
assessment and management. Furthermore, in many cases, uncontrolled symptoms and incomplete communication regarding life sustaining preferences and religious/spiritual concerns are avoidable causes of prolonged hospitalization with the added risks, costs, and inconvenience to families. For any given patient, each day in which pain, nausea, shortness of breath, anxiety, spiritual distress, and life-and-death decisions are not maximally supported can seem like an eternity. Uncontrolled pain leads to physiologic disturbances and poor patient experiences. In many cases, uncontrolled pain is an avoidable cause of prolonged hospitalization with the added risks, costs, and inconveniences to families. The Agency for Healthcare Research and Quality suggests that patient safety and satisfaction cannot be optimized in hospital-based care without first raising the bar for pain assessment. The authors note that the scope of the problem is vast: 62% of the 35 million discharges from U.S. hospitals include surgery or interventional procedures, and over 80% of these patients experience post-operative or procedural pain.104 These patients are at risk for adverse cardiac events, swings in blood sugar, the development of chronic pain and addiction, and psychological distress such as anxiety and sleeplessness. The American Academy of Pain Medicine also notes that patients who experience uncontrolled pain experience higher absenteeism and lost productivity, with an annual estimated cost of about $300 billion.105 Even when pain is recognized and treated promptly, the safe and effective use of medications is a serious challenge for hospital care. A sentinel study from 1997 showed that 29% of adverse medication events in the hospital were opioid-related.106 For post-operative patients, the evidence of avoidable health system costs of uncontrolled pain and adverse opioid events is mounting. A study from 2013 showed that adverse opioid events in surgical patients are associated with significantly higher costs, length of stay, and readmission rates.107 A retrospective review of 320,000 patients showed that patients with documented adverse events – including constipation, altered mental status, respiratory depression, and poorly controlled pain – had on average 30% higher in-hospital costs. These patients also had a three-fold greater odds of being a cost and length of stay outlier that were more likely to be readmitted within 30 days. It is expected the benefits of reduced length of stay, decreased direct hospital costs, and readmission rates will be experienced directly by those patients who receive palliative care specialty services and will be multiplied as the standards for expert pain management are raised across other clinical services who deliver care to patients with advanced age, cancer, and surgical needs. Although peer reviewed studies in palliative care do not traditionally quantify the financial value of good pain control or addressing the treatment preferences and spiritual concerns of patients, these clearly have value to patients and families. Using the same approach to value category 2 metrics, these downstream outcomes are a smaller reflection of the larger value calculated through cost avoidance using data from patients previously seen at University Hospital. Early palliative care intervention is a specific goal for the LIFE Care/Palliative Medicine service, which offers the greatest ability to improve health outcomes, patient experience, and reduced

costs. University Hospital has valued the outcomes of the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service project through its ability to achieve the waiver goals, meet community needs, meet the level of required investment, and include the value of palliative care in the context of both the inpatient and outpatient setting. In 2011, University Health System cared for over 233,000 unique patients, including about 67,000 Emergency Center visits, 400,000 outpatient clinic visits, and 20,000 inpatient discharges. The primary inpatient facility in University Hospital, which operates 496 beds and will expand to about 750 beds when the new University Tower is completed in 2014. University Hospital is a Level One Trauma Center, a world-renowned solid organ transplant center, and a referral center for a broad array of life-threatening conditions including metastatic cancer, end-stage renal disease, cirrhosis, heart failure, AIDS, and vascular disease. South and Central Texas have some of the nation’s highest rates of diabetes and obesity. During the calendar year 2012, the LIFE Care/Palliative Medicine program provided 638 inpatient consultations and over 120 outpatient clinic visits. Preliminary analysis from an internal database reveals that 50% of these patients suffered from advanced cancer, 30% had brain injury or polytrauma, and 30% faced end-stage organ disease such renal failure and cirrhosis, with some overlap among these groups. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost-savings, improved quality of life, and even prolongation of life. One large multi-institutional study that matched patients by severity of illness (propensity scores) showed that inpatient Palliative Care consultation significantly reduced direct and variable costs. For patients who were discharged alive, Palliative Care consultation correlated with an adjusted net savings of $1,700 per admission. And for patients who died in the hospital, savings exceeded $4,900 per admission. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial—those savings can be used to further improve and expand supportive care for all patients. At University Hospital, early analysis demonstrates similar cost-savings. One hundred and seventy patients seen by the LIFE Care/Palliative Medicine team during a six-month period were matched to about 9,000 patients with similar diagnoses and severity of illness. With conservative assumptions and excluding outliers, reduced direct and variable savings averaged $5,600 per admission. Consultations performed within 72 hours of admissions yielded cost-savings of $12,600 per admission, which further illustrates the need for early Palliative Care consultation. Opportunity costs not included in this analysis includes ICU bed days, which also decreased by an average of one day per admission and almost certainly resulted in reduced ICU mortality and Emergency Center throughput. Early palliative care involvement is the goal, which offers the greatest ability to improve health outcomes, patient experience, and cost avoidance.

<table>
<thead>
<tr>
<th>136141205.3.16</th>
<th>3.IT-13.1</th>
<th>Pain assessment (NQF-1637) (Non-standalone measure)</th>
</tr>
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<tbody>
<tr>
<td>PASS 1</td>
<td>University Hospital</td>
<td>TPI - 136141205</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
<td>Currently there is no standard for the percent documentation of pain assessment</td>
<td></td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>Project Planning – P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans to address pain assessment in palliative care patients. <strong>Data Source:</strong> Evidence of meetings, policies and procedures documented to demonstrate process.</td>
<td>Project Planning – P-2: Establish baseline rates for assessment and treatment of pain in palliative care patients. <strong>Data Source:</strong> EMR, Palliative Care database to document baseline rates of pain assessment and treatment.</td>
<td>Pain assessment – IT-13.1 Improvement Target: Of patients receiving palliative care who report pain when pain screening is done on the admission evaluation/initial encounter, the palliative care team will successfully provide a comprehensive clinical assessment to determine the severity, etiology and impact of pain within 24 hours of screening positive for pain to at least 75% of patients (479). <strong>Data Source:</strong> EMR, Palliative Care database</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $157,189</td>
<td>Process Milestone 2 Estimated Incentive Payment: $182,201</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $292,371</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $157,189</td>
<td>Year 3 Estimated Outcome Amount: $182,201</td>
<td>Year 4 Estimated Outcome Amount: $292,371</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,330,909
Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure) |
| Unique RHP ID#: 136141205.3.17 – PASS 1 |
| Performing Provider: University Hospital |
| TPI: 136141205 |

Outcome Measure Description:

Process milestones:
During DY2, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will specifically engage in Project Planning (P-1) for process improvement. This will include engaging multiple stakeholders, identification of current capacity and needed resources, determination of specific timelines and documentation and implementation of plans to address the outcome improvement measures for palliative care patients.

During DY3, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will use information gathered and systems developed during DY2 to establish baseline rates (P-2) for the outcome improvement measures for palliative care patients.

Outcome improvement measures:
Percentage of patients with chart documentation of preferences for life sustaining treatments.

**Numerator:** Patients whose medical record includes documentation of life sustaining preferences

**Denominator:** Seriously ill patients receiving specialty palliative care in an acute hospital setting.

**Exclusions:** patients with length of stay < 1 day in palliative care or <7 days in hospice.

**Data Source:** EHR, Palliative Care Database

DY4: Of patients seriously ill patients receiving specialty palliative care in an acute hospital setting, the palliative care team will successfully documentation of life sustaining preferences in least 75% of patients (479).

DY5: Of patients seriously ill patients receiving specialty palliative care in an acute hospital setting, the palliative care team will successfully documentation of life sustaining preferences in least 90% of patients (574).

Rationale:
The process metrics chosen are an essential to develop a systematic process for the quality improvement cycle related to fostering successful outcomes anticipated in DY4 and DY5. For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, life sustaining treatment preferences, and documentation of spiritual concerns) reflect some of the core quality measures needed to achieve excellence in patient care. These metrics also correlate with the selected Process and Improvement metrics. Patients report problems with hospital symptom management and continuity of care:

- 1 in 2 patients describe their hospital care as “suboptimal”\(^{110}\)
- 1 in 4 patients report inadequate treatment for pain and shortness of breath\(^{111}\)
- 1 in 3 families report inadequate emotional support\(^{112}\)
- 1 in 3 patients state they are poorly educated for pain and other symptom management after hospital discharge\(^{113}\)
- 1 in 3 patients are not provided plans for follow-care after hospital discharge\(^{114}\)

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112Ibid.
Over 50% of deaths in America occur in the hospital setting.\textsuperscript{115} 
Over 70% of patients who die in the hospital were admitted to the hospital in the previous 6 months.\textsuperscript{116} 
Only 40% of public hospitals have access to Palliative Care specialists.\textsuperscript{117} 
About 33% of patients enrolled in hospice die within one week.\textsuperscript{118}

Improving access to LIFE Care/Palliative Medicine services involves implementation of a comprehensive supportive service that inevitably relies on changing the culture in which the service is practiced. Referring physicians and physicians-in-training need to understand and appreciate the role that Palliative Care can play in improving patient and family satisfaction, pain and other symptom management, and in promoting patient and family-centered care. Education of referring physicians, especially primary care physicians and physicians-in-training, can deepen the appreciation for supportive care. Education in Palliative Care can also promote best practices and broad patient access to competent delivery of basics in Palliative Care, such as the safe use of opioids, emotional and spiritual aspects of care, and ethical issues related to surrogate decision-making and withdrawing or withholding life-sustaining interventions.

**Outcome Measure Valuation:**

For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, treatment preferences, and documentation of spiritual concerns) are valued based on their ability to demonstrate tangible achievement with various elements of a successful palliative care program and their impact on patient comfort, safety, and health care outcomes. One first step towards controlling pain and improving patient outcomes is to maximize and standardize the assessment and to anticipate the pain of our highest risk patients, especially those undergoing surgery or invasive procedures and those with advanced illness such as metastatic cancer. A consensus statement from an "International Expert Panel" out of Johns Hopkins in 2008 stated that opioids are an essential part of patient care for the elderly and patients with cancer.\textsuperscript{119} They recommended the use of evidenced-based medicine to establish local clinical practice guidelines for clinicians who prescribe opioids. They argue that increased awareness of medication profiles can promote effective and safe pain relief. Both the Agency for Health Care Research and the American Pain Society recommend balancing effective analgesia with effective monitoring, prevention, and management of adverse opioid events. The Category 3 metrics for this project will establish a systematic process to achieve a higher standard for pain assessment and management. Furthermore, in many cases, uncontrolled symptoms and incomplete communication regarding life sustaining preferences and religious/spiritual concerns are avoidable causes of prolonged hospitalization with the added risks, costs, and inconvenience to families. For any given patient, each day in which pain, nausea, shortness of breath, anxiety, spiritual distress, and life-and-death decisions are not maximally supported can seem like an eternity. Uncontrolled pain leads to physiologic disturbances and poor patient experiences. In many cases, uncontrolled pain is an avoidable cause of prolonged hospitalization with the added risks, costs, and inconveniences to families. The Agency for Healthcare Research and Quality

\textsuperscript{114}Ibid.  
suggests that patient safety and satisfaction cannot be optimized in hospital-based care without first raising the bar for pain assessment. The authors note that the scope of the problem is vast: 62% of the 35 million discharges from U.S. hospitals include surgery or interventional procedures, and over 80% of these patients experience post-operative or procedural pain. These patients are at risk for adverse cardiac events, swings in blood sugar, the development of chronic pain and addiction, and psychological distress such as anxiety and sleeplessness. The American Academy of Pain Medicine also notes that patients who experience uncontrolled pain experience higher absenteeism and lost productivity, with an annual estimated cost of about $300 billion. Even when pain is recognized and treated promptly, the safe and effective use of medications is a serious challenge for hospital care. A sentinel study from 1997 showed that 29% of adverse medication events in the hospital were opioid-related. For post-operative patients, the evidence of avoidable health system costs of uncontrolled pain and adverse opioid events is mounting. A study from 2013 showed that adverse opioid events in surgical patients are associated with significantly higher costs, length of stay, and readmission rates. A retrospective review of 320,000 patients showed that patients with documented adverse events – including constipation, altered mental status, respiratory depression, and poorly controlled pain – had on average 30% higher in-hospital costs. These patients also had a three-fold greater odds of being a cost and length of stay outlier that were more likely to be readmitted within 30 days. It is expected the benefits of reduced length of stay, decreased direct hospital costs, and readmission rates will be experienced directly by those patients who receive palliative care specialty services and will be multiplied as the standards for expert pain management are raised across other clinical services who deliver care to patients with advanced age, cancer, and surgical needs. Although peer reviewed studies in palliative care do not traditionally quantify the financial value of good pain control or addressing the treatment preferences and spiritual concerns of patients, these clearly have value to patients and families. Using the same approach to value category 2 metrics, these downstream outcomes are a smaller reflection of the larger value calculated through cost avoidance using data from patients previously seen at University Hospital. Early palliative care intervention is a specific goal for the LIFE Care/Palliative Medicine service, which offers the greatest ability to improve health outcomes, patient experience, and reduced costs. University Hospital has valued the outcomes of the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service project through its ability to achieve the waiver goals, meet community needs, meet the level of required investment, and include the value of palliative care in the context of both the inpatient and outpatient setting. In 2011, University Health System cared for over 233,000 unique patients, including about 67,000 Emergency Center visits, 400,000 outpatient clinic visits, and 20,000 inpatient discharges. The primary inpatient facility in University Hospital, which operates 496 beds and will expand to about 750 beds when the new University Tower is completed in 2014. University Hospital is a Level One Trauma Center, a

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world-renowned solid organ transplant center, and a referral center for a broad array of life-threatening conditions including metastatic cancer, end-stage renal disease, cirrhosis, heart failure, AIDS, and vascular disease. South and Central Texas have some of the nation’s highest rates of diabetes and obesity. During the calendar year 2012, the LIFE Care/Palliative Medicine program provided 638 inpatient consultations and over 120 outpatient clinic visits. Preliminary analysis from an internal database reveals that 50% of these patients suffered from advanced cancer, 30% had brain injury or polytrauma, and 30% faced end-stage organ disease such renal failure and cirrhosis, with some overlap among these groups. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost-savings, improved quality of life, and even prolongation of life. One large multi-institutional study that matched patients by severity of illness (propensity scores) showed that inpatient Palliative Care consultation significantly reduced direct and variable costs. For patients who were discharged alive, Palliative Care consultation correlated with an adjusted net savings of $1,700 per admission. And for patients who died in the hospital, savings exceeded $4,900 per admission. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial—those savings can be used to further improve and expand supportive care for all patients. At University Hospital, early analysis demonstrates similar cost-savings. One hundred and seventy patients seen by the LIFE Care/Palliative Medicine team during a six-month period were matched to about 9,000 patients with similar diagnoses and severity of illness. With conservative assumptions and excluding outliers, reduced direct and variable savings averaged $5,600 per admission. Consultations performed within 72 hours of admissions yielded cost-savings of $12,600 per admission, which further illustrates the need for early Palliative Care consultation. Opportunity costs not included in this analysis includes ICU bed days, which also decreased by an average of one day per admission and almost certainly resulted in reduced ICU mortality and Emergency Center throughput. Early palliative care involvement is the goal, which offers the greatest ability to improve health outcomes, patient experience, and cost avoidance.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>136141205.2.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Currently there is no standard for the percent documentation of treatment preferences</td>
</tr>
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<td><strong>Data Source:</strong> Evidence of meetings, policies and procedures documented to demonstrate process.</td>
<td><strong>Data Source:</strong> EMR, Palliative Care database to document baseline rates of pain assessment and treatment.</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $157,190</td>
<td>Year 3 Estimated Outcome Amount: $182,202</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,330,911
Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified)</th>
<th>Non-standalone measure</th>
</tr>
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<tr>
<td>Unique RHP ID#: 136141205.3.18 – PASS 1</td>
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<tr>
<td>Performing Provider: University Hospital</td>
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<tr>
<td>TPI: 136141205</td>
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Outcome Measure Description:

**Process milestones:**

During **DY2**, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will specifically engage in Project Planning (P-1) for process improvement. This will include engaging multiple stakeholders, identification of current capacity and needed resources, determination of specific timelines and documentation and implementation of plans to address the outcome improvement measures for palliative care patients.

During **DY3**, the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service will use information gathered and systems developed during DY2 to establish baseline rates (P-2) for the outcome improvement measures for palliative care patients.

**Outcome improvement measures:**

**Numerator**: Number of patients with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.

**Denominator**: Total number of patient’s discharged from palliative care during the designated reporting period.

**Data Source**: EHR, Palliative Care Database

**DY4**: Of patients discharged from palliative care during the designated reporting period, the palliative care team will successfully document spiritual/religious concerns or that the patient/family did not want to discuss in least 75% of patients (479).

**DY5**: Of patients discharged from palliative care during the designated reporting period, the palliative care team will successfully document spiritual/religious concerns or that the patient/family did not want to discuss in least 90% of patients (574).

**Rationale:**

The process metrics chosen are an essential to develop a systematic process for the quality improvement cycle related to fostering successful outcomes anticipated in DY4 and DY5. For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, life sustaining treatment preferences, and documentation of spiritual concerns) reflect some of the core quality measures needed to achieve excellence in patient care. These metrics also correlate with the selected Process and Improvement metrics. Patients report problems with hospital symptom management and continuity of care:

- 1 in 2 patients describe their hospital care as “suboptimal”\(^{126}\)
- 1 in 4 patients report inadequate treatment for pain and shortness of breath\(^{127}\)
- 1 in 3 families report inadequate emotional support\(^{128}\)
- 1 in 3 patients state they are poorly educated for pain and other symptom management after hospital discharge\(^{129}\)

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\(^{128}\) Ibid.

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1295 ★ RHP 6 Plan ★ March 8, 2013 University Hospital
• 1 in 3 patients are not provided plans for follow-care after hospital discharge.¹³⁰
• Over 50% of deaths in America occur in the hospital setting.¹³¹
• Over 70% of patients who die in the hospital were admitted to the hospital in the previous 6 months.¹³²
• Only 40% of public hospitals have access to Palliative Care specialists.¹³³
• About 33% of patients enrolled in hospice die within one week.¹³⁴

Improving access to LIFE Care/Palliative Medicine services involves implementation of a comprehensive supportive service that inevitably relies on changing the culture in which the service is practiced. Referring physicians and physicians-in-training need to understand and appreciate the role that Palliative Care can play in improving patient and family satisfaction, pain and other symptom management, and in promoting patient and family-centered care. Education of referring physicians, especially primary care physicians and physicians-in-training, can deepen the appreciation for supportive care. Education in Palliative Care can also promote best practices and broad patient access to competent delivery of basics in Palliative Care, such as the safe use of opioids, emotional and spiritual aspects of care, and ethical issues related to surrogate decision-making and withdrawing or withholding life-sustaining interventions.

Outcome Measure Valuation:

For Category 3 outcomes, the three non-standalone metrics (chart documentation of pain assessment, treatment preferences, and documentation of spiritual concerns) are valued based on their ability to demonstrate tangible achievement with various elements of a successful palliative care program and their impact on patient comfort, safety, and health care outcomes. One first step towards controlling pain and improving patient outcomes is to maximize and standardize the assessment and to anticipate the pain of our highest risk patients, especially those undergoing surgery or invasive procedures and those with advanced illness such as metastatic cancer. A consensus statement from an "International Expert Panel" out of Johns Hopkins in 2008 stated that opioids are an essential part of patient care for the elderly and patients with cancer.¹³⁵ They recommended the use of evidenced-based medicine to establish local clinical practice guidelines for clinicians who prescribe opioids. They argue that increased awareness of medication profiles can promote effective and safe pain relief. Both the Agency for Health Care Research and the American Pain Society recommend balancing effective analgesia with effective monitoring, prevention, and management of adverse opioid events. The Category 3 metrics for this project will establish a systematic process to achieve a higher standard for pain assessment and management. Furthermore, in many cases, uncontrolled symptoms and incomplete communication regarding life sustaining preferences and religious/spiritual concerns are avoidable causes of prolonged hospitalization with the added risks, costs, and inconvenience to families. For any given patient, each day in which pain, nausea, shortness of breath, anxiety, spiritual distress, and life-and-death decisions are not maximally supported can seem like an eternity. Uncontrolled pain leads to physiologic disturbances and poor patient experiences. In

¹³⁰Ibid.
¹³¹Ibid.
many cases, uncontrolled pain is an avoidable cause of prolonged hospitalization with the added risks, costs, and inconveniences to families. The Agency for Healthcare Research and Quality suggests that patient safety and satisfaction cannot be optimized in hospital-based care without first raising the bar for pain assessment. The authors note that the scope of the problem is vast: 62% of the 35 million discharges from U.S. hospitals include surgery or interventional procedures, and over 80% of these patients experience post-operative or procedural pain. These patients are at risk for adverse cardiac events, swings in blood sugar, the development of chronic pain and addiction, and psychological distress such as anxiety and sleeplessness. The American Academy of Pain Medicine also notes that patients who experience uncontrolled pain experience higher absenteeism and lost productivity, with an annual estimated cost of about $300 billion. Even when pain is recognized and treated promptly, the safe and effective use of medications is a serious challenge for hospital care. A sentinel study from 1997 showed that 29% of adverse medication events in the hospital were opioid-related. For post-operative patients, the evidence of avoidable health system costs of uncontrolled pain and adverse opioid events is mounting. A study from 2013 showed that adverse opioid events in surgical patients are associated with significantly higher costs, length of stay, and readmission rates. A retrospective review of 320,000 patients showed that patients with documented adverse events – including constipation, altered mental status, respiratory depression, and poorly controlled pain – had on average 30% higher in-hospital costs. These patients also had a three-fold greater odds of being a cost and length of stay outlier that were more likely to be readmitted within 30 days. It is expected the benefits of reduced length of stay, decreased direct hospital costs, and readmission rates will be experienced directly by those patients who receive palliative care specialty services and will be multiplied as the standards for expert pain management are raised across other clinical services who deliver care to patients with advanced age, cancer, and surgical needs. Although peer reviewed studies in palliative care do not traditionally quantify the financial value of good pain control or addressing the treatment preferences and spiritual concerns of patients, these clearly have value to patients and families. Using the same approach to value category 2 metrics, these downstream outcomes are a smaller reflection of the larger value calculated through cost avoidance using data from patients previously seen at University Hospital. Early palliative care intervention is a specific goal for the LIFE Care/Palliative Medicine service, which offers the greatest ability to improve health outcomes, patient experience, and reduced costs. University Hospital has valued the outcomes of the Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service project through its ability to achieve the waiver goals, meet community needs, meet the level of required investment, and include the value of palliative care in the context of both the inpatient and outpatient setting. In 2011, University Health System cared for over 233,000 unique patients, including about 67,000 Emergency Center visits, 400,000 outpatient clinic visits, and 20,000 inpatient discharges. The primary inpatient facility in

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University Hospital, which operates 496 beds and will expand to about 750 beds when the new University Tower is completed in 2014. University Hospital is a Level One Trauma Center, a world-renowned solid organ transplant center, and a referral center for a broad array of life-threatening conditions including metastatic cancer, end-stage renal disease, cirrhosis, heart failure, AIDS, and vascular disease. South and Central Texas have some of the nation’s highest rates of diabetes and obesity. During the calendar year 2012, the LIFE Care/Palliative Medicine program provided 638 inpatient consultations and over 120 outpatient clinic visits. Preliminary analysis from an internal database reveals that 50% of these patients suffered from advanced cancer, 30% had brain injury or polytrauma, and 30% faced end-stage organ disease such renal failure and cirrhosis, with some overlap among these groups. Cost-savings or cost-avoidance is increasingly recognized as a secondary outcome associated with Palliative Care programs. When patients and families are provided early supportive care, the culture of automatic escalation of care is mitigated. This can result in cost-savings, improved quality of life, and even prolongation of life.\textsuperscript{140} One large multi-institutional study that matched patients by severity of illness (propensity scores) showed that inpatient Palliative Care consultation significantly reduced direct and variable costs.\textsuperscript{141} For patients who were discharged alive, Palliative Care consultation correlated with an adjusted net savings of $1,700 per admission. And for patients who died in the hospital, savings exceeded $4,900 per admission. When these savings are multiplied across hundreds of consultations per year, and increased ICU bed availability is added in, the savings to the healthcare system are substantial—those savings can be used to further improve and expand supportive care for all patients. At University Hospital, early analysis demonstrates similar cost-savings. One hundred and seventy patients seen by the LIFE Care/Palliative Medicine team during a six-month period were matched to about 9,000 patients with similar diagnoses and severity of illness. With conservative assumptions and excluding outliers, reduced direct and variable savings averaged $5,600 per admission. Consultations performed within 72 hours of admissions yielded cost-savings of $12,600 per admission, which further illustrates the need for early Palliative Care consultation. Opportunity costs not included in this analysis includes ICU bed days, which also decreased by an average of one day per admission and almost certainly resulted in reduced ICU mortality and Emergency Center throughput. Early palliative care involvement is the goal, which offers the greatest ability to improve health outcomes, patient experience, and cost avoidance.


\textsuperscript{141} Morrison, et al. Cost Savings Associated With US Hospital Palliative Care Consultation Programs. \textit{Arch Intern Med.} 2008;168(16):1783-1790.
<table>
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<tr>
<th>136141205.3.18 PASS 1</th>
<th>3.IT-13.5</th>
<th>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)</th>
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| University Hospital | TPI - 136141205 |

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<th>Related Category 1 or 2 Projects:</th>
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<th>Starting Point/Baseline:</th>
<th>Currently there is no standard for the percent documentation of a discussion of spiritual/religions concerns</th>
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<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
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**Process Milestone 1**
Project Planning – P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans to address pain assessment in palliative care patients.

**Data Source:** Evidence of meetings, policies and procedures documented to demonstrate process.

Process Milestone 1 Estimated Incentive Payment: $157,189

**Process Milestone 2**
Project Planning – P-2: Establish baseline rates for assessment and treatment of pain in palliative care patients.

**Data Source:** EMR, Palliative Care database to document baseline rates of pain assessment and treatment.

Process Milestone 2 Estimated Incentive Payment: $182,202

**Outcome Improvement Target 1**
Spiritual/Religious Concerns – IT-13.5
Improvement Target: Of patients discharged from palliative care during the designated reporting period, the palliative care team will successfully document spiritual/religious concerns or that the patient/family did not want to discuss in least 75% of patients (479).

**Data Source:** EMR, Palliative Care database

Outcome Improvement Target 1 Estimated Incentive Payment: $292,371

**Year 2 Estimated Outcome Amount:** $157,189

**Year 3 Estimated Outcome Amount:** $182,202

**Year 4 Estimated Outcome Amount:** $292,371

**Year 5 Estimated Outcome Amount:** $699,148

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,330,910
Identifying Outcome Measure and Provider Information:

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<th>Title of Outcome Measure (Improvement Target): IT – 6.1 Percent improvement over baseline of patient satisfaction scores</th>
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<tr>
<td>UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136141205.3.19 – PASS 2</td>
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<tr>
<td>Provider Name: University Hospital</td>
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<td>TPI: 136141205</td>
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</table>

Outcome Measure Description:

**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Percent improvement over baseline of patient satisfaction scores, among non-English speaking patients, for one or more of the patient satisfaction domains that the provider targets for improvement, utilizing the HCAHPS survey.

| a Numerator: Percent improvement in targeted patient satisfaction domain |
| b Data Source: Patient survey |
| c Denominator: Number of patients who were administered the survey |

Process Milestones

- **DY2**
  - P-1 Project planning-engage stakeholders
  - P-2 Establish baseline rates

- **DY3**
  - P-3 Establish and test data systems

- **DY4**
  - P-4 Conduct Plan, Do, Study and Act

- **DY5**
  - P-4 Conduct Plan, Do, Study and Act
  - P-4 Disseminate Findings

Improvement Milestones

- **DY4**
  - **IT-6.1 patient satisfaction:** Exceed Teaching Hospital benchmarks by 5% by end of DY 4, show improvement over baseline of patient satisfaction scores at a level to be determined.

- **DY5**
  - **IT-6.1 patient satisfaction:** Exceed Teaching Hospital benchmarks by 5% by end of DY 5, show improvement over baseline of patient satisfaction scores at a level to be determined.

**DY 2: P-1 & P-2:** Project planning/establish baseline rates: develop appropriate metric for measuring HCAHPS patient experience data for patients who have selected a language other than English as their preference. [P-1] Conduct an analysis to determine gaps in language access and culturally competent care. [P-5] Train additional volunteer health care interpreters and assess their competency.

Develop job descriptions and functions for In-house Healthcare Interpreter Service personnel. Hire manager. Begin process of identifying and evaluating vendors that offer web-based video interpretation tools.

Develop goals and processes for Healthcare Interpreter Services. [P-5]: Hire and train certified Spanish translation staff to translate written documents and provide web-based video interpretation services 24/7.

Begin monitoring HCAHPS metrics to identify key drivers for the patient experience for non-English speaking patients. Develop communication materials to increase staff/MD awareness of new program and processes.

DY 4 & DY5: P-4: Conduct Plan Do Study Act cycles to improve data collection and intervention activities: Target: IT-6.1 Meet Teaching Hospital cohort CAHPS benchmarks in all Dimensions of Service by DY 4. Show improvement over baseline of patient satisfaction scores at a level to be determined.

DY 5: P-5: Disseminate Findings, including lessons learned and best practices, to stakeholders across Bexar County community as well as through articles, webinars, and presentations through the Teaching Hospitals of Texas, Texas Hospital Association and NRC Picker.

Improvement Target: IT-6.1 Exceed Teaching Hospital benchmarks by 5% by end of DY 5, show improvement over baseline of patient satisfaction scores at a level to be determined.

**Rationale:**

The rationale for selecting the following process milestones reflect the methodical approach that will be undertaken to engage stakeholders, identify required resources, develop an implementation and project monitoring plan to ensure appropriate alignment with improving and reporting of data and systems provide the necessary infrastructure to ensure timely and accurate reporting of patient satisfaction scores.

**Process Milestones**

Process milestones (P-1, P-2 and P-3) were chosen as part of ensure the accurate and appropriate collection of patient experience in DY2 and DY3. With the implementation of value-based purchasing, as well as research demonstrating the link between the patient experience and other hospital quality metrics, it is critically important for University Health System to ensure that a focus is on placed on HCAHPS improvement from the onset. The project to improve effective communication between healthcare professionals with patients and families through interpreter/document translation enhancements will enable University Health System improve the patient experience as measured by achieving new levels of performance on HCAHPS, and ultimately deliver higher quality care. The culmination of this efforts will be further calibrated with process milestones P-4 conduct a plan, do study and act as well as share finding (P-5) and lessons learned with regional hospital partners and related organizations regarding best practices and opportunities to improve patient experience.

**Improvement Targets**

This outcome improvement measure was chosen for its direct relation to the goals of the triple aim: assuring patients receive high-quality and patient-centered care, in the most effective way
as well as developing and maintaining a coordinated care delivery system that address patient preferences including cultural and linguistic orientation and thereby contributes to patients receiving high-quality, patient-centered care in the most cost-effective way. In addition, intent of measuring patient experience is that it enhances public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Outcome Measure Valuation:**

University Health System’s efforts to successfully strengthen access to culturally competent patient-centered care through strategies that promote timely oral interpretation/translation services, improve the fluid exchange of health information between patients and healthcare professionals and promote opportunities for patient to adhere to prescribed clinical care and treatment regimens will in large be self-evident and in particular demonstrated by an increase in patient satisfaction scores regarding quality of care received. Such efforts will also strengthen waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
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</thead>
<tbody>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td></td>
<td>[P-3]: Develop and test data systems</td>
<td></td>
<td>[P-4]: Conduct a Plan, Do, Study and Act</td>
<td></td>
<td>[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
</tr>
<tr>
<td>Data Source: Team meeting minutes, data elements identified in valuation/assessment and project planning documentation.</td>
<td></td>
<td>Data Source: Log of test results</td>
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<td>Data Source: QI results and documentation.</td>
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<td>Data Source: Meeting minutes/report outs</td>
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<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td></td>
<td></td>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $738,960</td>
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<td>Data Source: NRC Picker</td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $197,640</td>
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</table>

<table>
<thead>
<tr>
<th>Process Milestone 4 [P-4]: Conduct a Plan, Do, Study and Act</th>
<th>Data Source: QI results and documentation.</th>
<th>Outcome Improvement Target 1 [IT-6.1]: Percent improvement over baseline of patient satisfaction scores: 5%</th>
<th>Data Source: Patient satisfaction survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $229,442</td>
<td></td>
<td>Outcome Improvement Target 2 [IT-6.1]: Percent improvement over baseline of patient satisfaction scores: 5%</td>
<td>Data Source: Patient satisfaction survey</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,764,933</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $395,280</td>
<td>Year 3 Estimated Outcome Amount: $458,884</td>
<td>Year 4 Estimated Outcome Amount: $738,960</td>
<td>Year 5 Estimated Outcome Amount: $1,764,933</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,358,057</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT – 12.1 Breast Cancer Screening
Unique RHP Outcome ID #: 136141205.3.21 – PASS 2
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

Outcome Measure Description:

IT – 12.1 - Breast Cancer Screening

Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.

Denominator: Number of women aged 40 to 69 in the patient or target population. Exclusion: women who have had a bilateral mastectomy are excluded.

Data Source: EHR, Claims, Visit management system

Process Milestones:

DY2:
   - P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

DY3:
   - P-2: Establish Baseline Rates

Outcome Improvement Targets for each year:

DY4:

- **DY4**- Increase IT – 12.1 - Breast Cancer Screening by TBD percent (%) over baseline year for number of women aged 40 to 69 that have received an annual mammogram during the reporting period.

DY 5:

- **DY5**- Increase IT – 12.1 - Breast Cancer Screening by TBD over baseline year those number of women aged 40 to 69 that have received an annual mammogram during the reporting period.

The process milestones will be reported on in DY 2-3 and specifically outlined as P-1 Project Planning and P-2 Establish Baseline Rates. Improvement targets in DY 4-5 and their methodology including corresponding metrics, data, and sources for data extraction, goals and rationale will also be specified to report on project specific outcome. Specifically, baseline
measures will be established, goals will be set for outcomes measure in DY 4 and DY5.

**Rationale:**

Less than half of all Americans receive the recommended levels of screening associated with clinical preventive care. Studies confirm the clinical and economic benefits of providing timely access to preventive services by significantly reducing the onset of chronic health conditions that include cancer.

Screening for breast cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings.

Expanding primary care and prevention and establishing a usual source of enhance screening behaviors including adherence to clinical preventive care such as breast cancer screening.

Project goal in DY 4 and in DY 5 is to increase access and coverage to clinical preventive care; specifically ensuring that women receive a mammogram based on clinical preventive guidelines. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare University Health System to report outcomes in DY4 and DY5. The two process milestones selected are:

**P-1:** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**P-2:** Establish Baseline Rates

**Quality Improvement Process:** To ensure that project performance milestone are met an evaluation plan will be embedded within project activities and will guided by elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements will include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. The strength of utilizing this framework will also ensure that barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus specific components of the intervention, clearly identifying the target population and target setting and effectively capturing fidelity of the project activities through a focused research design (Glasgow & Emmons, 2007). Evaluation of project success will in large part be self-evident. That is, accomplishment of previously specified program activities will be specific, measurable, attainable, relevant and timely in helping to strengthen the health status of women.
residing in Bexar County/San Antonio, Texas.

The improvement targets were chosen as they reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests identified in the U.S. Preventive Services Task Force (USPSTF) recommendations. The objectives for Healthy People 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are considered intermediate markers of cancer screening success.

**Outcome Measure Valuation:**

The USPSTF make evident the clinical and economic benefits of preventive screening. That is providing timely access to preventive services has been shown to significantly reduce the onset of chronic health conditions such as diabetes, infectious disease such as flu and pneumonia and reducing mortality by detecting cancer and other diseases at much earlier stage.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1**  
  P-1 Project Planning: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
  Data Source: Team meeting minutes, data elements identified in evaluation/assessment and project planning documentation.  
  Process Milestone 1 Estimated Incentive Payment: $115,290 | **Process Milestone 2**  
  P-2 Establish Baseline Rates  
  Establish baseline rates breast cancer screening from DY 2.  
  Data Source: Electronic Health Record  
  Process Milestone 2 Estimated Incentive Payment: $133,841 | **Outcome Improvement Target 1**  
  IT-12.1 Breast Cancer Screening baseline year for number of women aged 40 to 69 that have received an annual mammogram during the reporting period.  
  Improvement Target: TBD%  
  Goal: Increase in percentage of breast cancer screens.  
  Data Source: Electronic Health Record  
  Outcome Improvement Target 1 Estimated Incentive Payment: $215,530 | **Outcome Improvement Target 2**  
  IT-12.1 Breast Cancer Screening baseline year for number of women aged 40 to 69 that have received an annual mammogram during the reporting period.  
  Improvement Target: TBD%  
  Goal: Increase in percentage of breast cancer screens.  
  Data Source: Electronic Health Record  
  Outcome Improvement Target 2 Estimated Incentive Payment: $514,772 |
| Year 2 Estimated Outcome Amount: $115,290 | Year 3 Estimated Outcome Amount: $133,841 | Year 4 Estimated Outcome Amount: $215,530 | Year 5 Estimated Outcome Amount: $514,772 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $979,433
### Identifying Outcome Measure and Provider Information:

**Title of Outcome Measure (Improvement Target):** IT – 12.2  Cervical Cancer Screening  
**Unique RHP Outcome ID #:** 136141205.3.22 – PASS 2  
**Provider name:** University Hospital  
**TPI:** 136141205  

### Outcome Measure Description:

**IT – 12.2 - Cervical Cancer Screening**

**Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

**Denominator:** Women aged 21 to 64 in the patient population. Exclusion women who have had a complete hysterectomy with no residual cervix are excluded.

**Data Source:** EHR, Claims

### Process Milestones:

**DY2:**
- **P-1:** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**DY3:**
- **P-2:** Establish Baseline Rates

### Outcome Improvement Targets for each year:

**DY4:**
- **IT-12.2 - Cervical Cancer Screening** over baseline year by **TBD** percent (%) for those number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

**DY 5:**
- **IT-12.2 - Cervical Cancer Screening** over baseline year by **TBD** percent (%) for those number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

The process milestones will be reported on in DY 2-3 and specifically outlined as IP-1 Project Planning and P-2 Establish Baseline Rates. Improvement targets in DY 4-5 and their methodology including corresponding metrics, data, and sources for data extraction, goals and rationale will also be specified to report on project specific outcome. Specifically, baseline measures will be established, goals will be set for outcomes measure in DY 4 and DY5.
**Rationale:**
Less than half of all Americans receive the recommended levels of screening associated with clinical preventive care. Studies confirm the clinical and economic benefits of providing timely access to preventive services by significantly reducing the onset of chronic health conditions that include cancer.

Screening for cervical cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings.

Expanding primary care and prevention and establishing a usual source of enhance screening behaviors including adherence to clinical preventive care such as cervical cancer screening.

Project goal in DY 4 and in DY 5 is to increase access and coverage to clinical preventive care; specifically ensuring that women receive a cervical screening based on clinical preventive guidelines. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare University Health System to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

**Quality Improvement Process:** To ensure that project performance milestone are met an evaluation plan will be embedded within project activities and will guided by elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements will include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. The strength of utilizing this framework will also ensure that barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus specific components of the intervention, clearly identifying the target population and target setting and effectively capturing fidelity of the project activities through a focused research design (Glasgow & Emmons, 2007). Evaluation of project success will in large part be self-evident. That is, accomplishment of previously specified program activities will be specific, measurable, attainable, relevant and timely in helping to strengthen the health status of women.
residing in Bexar County/San Antonio, Texas.

The improvement targets were chosen as they reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests identified in the U.S. Preventive Services Task Force (USPSTF) recommendations. The objectives for Healthy People 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are considered intermediate markers of cancer screening success.

Outcome Measure Valuation:

The USPSTF make evident the clinical and economic benefits of preventive screening. That is providing timely access to preventive services has been shown to significantly reduce the onset of chronic health conditions such as diabetes, infectious disease such as flu and pneumonia and reducing mortality by detecting cancer and other diseases at much earlier stage.
### 3.IT-12.2 Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-1 Project Planning: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>P-2 Establish Baseline Rates, establish baseline rates breast cancer screening from DY 2. Data Source: Electronic Health Record</td>
<td>IT-12.2 Cervical Cancer Screening over baseline for those number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Improvement Target: TBD% over baseline (DY2) Goal: Increase number of cervical cancer screens. Data Source: Electronic Health Record</td>
<td>IT-12.2 Cervical Cancer Screening over baseline for those number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Improvement Target: TBD% over baseline (DY2) Goal: Increase number of cervical cancer screens. Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Data Source: Team meeting minutes, data elements identified in evaluation/assessment and project planning documentation.</td>
<td>Process Milestone 2 Estimated Incentive Payment: $133,841</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $215,530</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $514,772</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $115,290</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $115,290</td>
<td>Year 3 Estimated Outcome Amount: $133,841</td>
<td>Year 4 Estimated Outcome Amount: $215,530</td>
<td>Year 5 Estimated Outcome Amount: $514,772</td>
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</tbody>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $979,433**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT – 12.3 - Colorectal Cancer Screening |
| Unique RHP Outcome ID #: 136141205.3.23 – PASS 2 |
| Provider name: University Hospital |
| TPI: 136141205 |

**Outcome Measure Description:**

IT – 12.3 – Colorectal Cancer Screening

**Numerator:** Number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every 10 years

**Denominator:** Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

**Data Source:** EHR, Claims

**Process Milestones:**

**DY2:**
- **P-1:** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**DY3:**
- **P-2:** Establish Baseline Rates

**Outcome Improvement Targets for each year:**

**DY4:**

- **DY4**- Increase 12.3 – Colorectal Cancer Screening by TBD percent (%) over baseline year for those number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every 10 years

**DY 5:**

- **DY5**- Increase 12.3 – Colorectal Cancer Screening by TBD percent (%) over baseline year for those number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every 10 years

The process milestones will be reported on in DY 2-3 and specifically outlined as IP-1 Project Planning and P-2 Establish Baseline Rates. Improvement targets in DY 4-5 and their methodology including corresponding metrics, data, and sources for data extraction, goals and rationale will also be specified to report on project specific outcome. Specifically, baseline measures will be established, goals will be set for outcomes measure in DY 4 and DY5.
**Rationale:**

Less than half of all Americans receive the recommended levels of screening associated with clinical preventive care. Studies confirm the clinical and economic benefits of providing timely access to preventive services by significantly reducing the onset of chronic health conditions that include cancer.

Screening for colorectal cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings.

Expanding primary care and prevention and establishing a usual source of enhance screening behaviors including adherence to clinical preventive care such as cervical cancer screening.

Project goal **in DY 4 and in DY 5 is to increase** access and coverage to clinical preventive care; specifically ensuring that women receive a colorectal screening based on clinical preventive guidelines. After establishing the baseline rates, outcome improvement targets will be determined.

To deliver these outcomes, process milestones were carefully selected. These milestones define the activities that will be undertaken to prepare University Health System to report outcomes in DY4 and DY5. The two process milestones selected are:

P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

P-2: Establish Baseline Rates

**Quality Improvement Process:** To ensure that project performance milestone are met an evaluation plan will be embedded within project activities and will guided by elements of the Framework for Program Evaluation in Public Health as outlined by the Centers for Disease Control and Prevention (CDC, 1999). Framework elements will include: engaging stakeholders, describing the program, focusing the evaluation design, appropriate and timely collection of data, justifying conclusions and ensuring use and sharing lessons learned. The strength of utilizing this framework will also ensure that barriers to effective implementation inherent in public health/health service interventions and translational research are reduced by placing focus specific components of the intervention, clearly identifying the target population and target setting and effectively capturing fidelity of the project activities through a focused research design (Glasgow & Emmons, 2007). Evaluation of project success will in large part be self-evident. That is, accomplishment of previously specified program activities will be specific, measurable, attainable, relevant and timely in helping to strengthen the health status of individuals residing in Bexar County/San Antonio, Texas.
The improvement targets were chosen as they reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests identified in the U.S. Preventive Services Task Force (USPSTF) recommendations. The objectives for Healthy People 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are considered intermediate markers of cancer screening success.

**Outcome Measure Valuation:**

USPSTF make evident the clinical and economic benefits of preventive screening. That is providing timely access to preventive services has been shown to significantly reduce the onset of chronic health conditions such as diabetes, infectious disease such as flu and pneumonia and reducing mortality by detecting cancer and other diseases at much earlier stage.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1 Project Planning: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>P-2 Establish Baseline Rates Establish baseline rates breast cancer screening from DY 2.</td>
<td>IT-12.3 Colorectal Cancer Screening over baseline year for those number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every 10 years</td>
<td>IT-12.3 Colorectal Cancer Screening over baseline year for those number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every 10 years</td>
</tr>
<tr>
<td>Data Source: Team meeting minutes, data elements identified in evaluation/assessment and project planning documentation</td>
<td>Data Source: Electronic Health Record</td>
<td>Improvement Target: TBD% over baseline (DY 2) Goal: Increase number of colorectal cancer screens. Data Source: Electronic Health Record</td>
<td>Improvement Target: TBD% over baseline (DY 2) Goal: Increase number of colorectal cancer screens. Data Source: Electronic Health Record</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $115,290</td>
<td>Process Milestone 2 Estimated Incentive Payment: $133,841</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $215,530</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $514,773</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $115,290
Year 3 Estimated Outcome Amount: $133,841
Year 4 Estimated Outcome Amount: $215,530
Year 5 Estimated Outcome Amount: $514,773

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $979,434
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): 3-IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate
Unique RHP outcome identification number: 136141205.3.24 – PASS 2
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT-2.11- Ambulatory Care Sensitive Conditions Admissions Rate

a). Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years

Inclusions: Total number of acute care hospitalizations for ambulatory care sensitive conditions* under age 75. This is based on a list of conditions developed by Billings et al., any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions; Chronic obstructive pulmonary diseases; Asthma; Heart Failure and pulmonary edema; Hypertension; Angina; Diabetes

Exclusions: Individuals 75 years of age and older; Death before discharge

b) Denominator: Total mid-year population under age 75.

c) Data source: EMR/IDX

d). Reasons/Rationale for selecting the outcome measures: Lack of access to medication or non-compliance with medication instructions are 2 key contributors to increased hospital admissions. Reducing unnecessary admissions benefits the patient and lowers costs for the hospital and the state. A potentially avoidable hospitalization a chronic health condition is commonly associated with a lack of access to appropriate ambulatory care. While not all admissions for chronic conditions are avoidable, it is assumed that appropriate ambulatory care can prevent avoidable admissions through more effective disease management, and control of acute episodes. A high rate of avoidable admissions reflects problems in obtaining access to appropriate primary care.

This pharmacist-led, chronic disease medication management program will have a direct impact on reducing avoidable admissions by reducing medication errors and adverse effects from medication use. Culturally competent pharmacists can effectively remove barriers and communicate with patients to educate them about medications, assure proper usage, answer questions, and provide social and emotional support to patients and their families.

Process Milestones:

- **DY2:** P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:** P-2 – Establish baseline rates
### Outcome Improvement Targets for each year:

- **DY4:** IT-2.11: Reduce total acute care hospitalizations for ambulatory care sensitive conditions under age 75 years. Target Outcome TBD
- **DY5:** IT-2.11: Reduce total acute care hospitalizations for ambulatory care sensitive conditions under age 75 years. Target Outcome TBD

### Rationale:

The rationale for this measure is as follows: “Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care.” Proper medication management for patients with chronic illnesses by a dedicated, specially trained pharmacist will be a significant contributing variable to lowering the rate of these admissions among the selected hub clinic population.

The Health System does not have such a program in place and this template will generate the data necessary to make a significant contribution to the medication management program and to the other care coordination efforts currently under way in the Health System – and those proposed by other Performing Providers under this 1115 Waiver. Improvement targets have not been identified, but will be during DYs 2 and 3.

### Outcome Measure Valuation:

Valuation is based on Achievement of Waiver Goals, Community Needs, Scope of Project, and Project Investment. The addition of a pharmacist to the ambulatory team in a specified Health System “hub clinic” will benefit the community patient, while reducing costs for unnecessary admissions. Value is estimated to be $3,567,935 over the remaining four-years of the waiver.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>136141205.2.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Planning in DY2 and baseline to be developed in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong></td>
<td><strong>Process Milestone 2 [P-2]:</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline rates</td>
<td>Reduce total acute care hospitalizations for ambulatory care sensitive conditions under age 75 years.</td>
<td>Reduce total acute care hospitalizations for ambulatory care sensitive conditions under age 75 years.</td>
</tr>
<tr>
<td>Data Source: EMR, IDX, Planning documentation</td>
<td>Data Source: EMR/IDX; Business Intelligence</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $419,985</td>
<td>Process Milestone 2 Estimated Incentive Payment: $487,564</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $785,145</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,875,241</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $419,985</td>
<td>Year 3 Estimated Outcome Amount: $487,564</td>
<td>Year 4 Estimated Outcome Amount: $785,145</td>
<td>Year 5 Estimated Outcome Amount: $1,875,241</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,567,935**
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-9.3- Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381 (Standalone measure)
Unique RHP outcome identification number: 136141205.3.25 – PASS 3
Performing Provider: University Hospital
TPI:136141205

Outcome Measure Description:

IT-9.3 – Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381
a. Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.
b. Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary and secondary diagnoses with the dates of service “Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail
c. Data Source: EHR, Claims

Process Milestones:

DY2: Process Milestone 1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans, relates directly to the milestones outlined in the Health System’s Category 1 Table for 136141205.1.8. This will be an expansion and enhancement initiative that targets delivery of patient-centered primary pediatric care in Bexar County, Texas. This undertaking will be made possible by leveraging the University Health System ambulatory network of clinical and preventive health clinics that are located in both high-growth and high-need areas delineated primarily by economically vulnerable populations that include minority individuals with multiple chronic conditions with limited and non-existed health insurance coverage.

For example project efforts will coincide with University Health System initiatives to partner with FQHCs to expand primary care capacity and access, oral health services, establish school-based clinics in major urban sectors of the city and health promotion efforts that enhance awareness of preventive care at all life stages to further help establish linkages between communities and preventive care. The experience of enhancing delivery of services to vulnerable populations gives us confidence that enhancing and expanding primary pediatric care and urgent pediatric care to our current clinic patient population and in partnership with the other performing providers in RHP6 will vastly improve management of pediatric asthma and related conditions.

DY3: Process Milestone 2: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Process Milestone 2 affords the opportunity to engage in quality improvements, share lessons learned, and effect rapid cycle improvements as appropriate.
Outcome Improvement Targets:
Category 3 Outcome: Reduce Pediatric/Young Adult Asthma Emergency Department Visits per NQF 1381, which populates both DYs 4 and 5 in anticipation of continuous improvement. The outcome improvement targets are yet to be determined (TBD) for DYs 4 and 5.

Rationale:

Process Milestone 1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. As noted above, the Health System currently employs telemedicine on a pilot basis for the Bexar County Adult Detention Center inmates. Expanding the technology to patient clinic sites, as well as to regional partners in the future, however, requires a completely new planning process.

Process Milestone 2: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. As mentioned, Process Milestone 2 affords the opportunity to engage in quality improvements, share lessons learned, and effect rapid cycle improvements as appropriate. This milestone is the natural extension to creation of the project plan as the steps to implementation are completed.

The outcome improvement targets for the selected Category 3 Outcome, “Reduce pediatric/young adult asthma emergency department visits per NQF 1381,” in both DY 4 and 5, will be determined in DY 2 for implementation in DY 3. This outcome improvement measure directly responds to the Waiver’s goals of a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated/integrated care delivery system; c) contribute to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and d) serve as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).

Outcome Measure Valuation:
Successful expansion in capacity/delivery of primary pediatric care and as a countermeasure to reduce inappropriate ED utilization for pediatric and young adult asthma patients will be an indicator for achievement of Waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve health outcomes and reduce emergency room utilization (containing cost growth).

When fully implemented – beyond DY5 – which includes expansion of primary pediatric care health service delivery for other highly prevalent conditions, the larger scope of the project should impact proper utilization in the form of increased routine and follow-up patient visits and encounters and reduced ED utilization.

This project requires investment as it complements HITECH funding goals. The hardware, software applications, human resources, and time to implement are of the highest organizational priority for the Health System. This particular project targets asthma, but the scope of utilization
for other chronic diseases and in other health care settings is potentially huge.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Starting Point/Baseline:</th>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</th>
<th>Outcome Improvement Target 1 [IT-9.3]: Reduce pediatric/young adult asthma emergency department visits per NQF 1381</th>
<th>Outcome Improvement Target 2 [IT-9.3]: Reduce pediatric/young adult asthma emergency department visits per NQF 1381</th>
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<tr>
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<td>To be developed in DY3</td>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $411,855</td>
<td>Process Milestone 2 Estimated Incentive Payment: $528,315</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $884,204</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $2,203,648</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Year 2 Estimated Outcome Amount: $411,855</td>
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<td>Year 4 Estimated Outcome Amount: $884,204</td>
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<td>Year 5 Estimated Outcome Amount: $2,203,648</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,028,022**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): <strong>IT-9.2 ED appropriate utilization:</strong> behavioral health/substance abuse</th>
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<tbody>
<tr>
<td>Unique RHP ID#: 136141205.3.26</td>
</tr>
<tr>
<td>Performing Provider Name: University Hospital</td>
</tr>
<tr>
<td>TPI: 136141205</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

#### Process Milestone 3
Develop and test data systems related to the identification of multiple hospitalization
   Data Source: Hospital admissions supplied by collaborating hospitals

#### Process Milestone 2
Establish baseline rates

Outcome measure: **IT-9.2 ED appropriate utilization: behavioral health/substance abuse**

### Rationale:

The process milestones (P-3 and P-2) were selected to prepare University Hospital for reporting of ED appropriate utilization rates for behavioral health. Since we have not determined at this time what the improvement targets for emergency utilization will be, we plan to determine them in our assessment work during the balance of DY2 for implementation in DY3.

### Outcome Measure Valuation:

By redirecting non emergent healthcare needs to community resources a reduction in denials will be supported while addressing a priority community need. Valuation methodology for outcome measures and their associated process milestones included, for this project, assessment of relative value for breadth of impact on the project (in terms of the three criterion of numbers of patients affected, the large scope of the project, and the positive impact on the community).
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<tr>
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<td>Starting Point/Baseline:</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<tr>
<td>Process Milestone 1 P-3 Develop and test data systems related to the identification of multiple hospitalization</td>
<td>Process Milestone 2 P-2 Establish baseline rates Data Source: University Hospital ER report</td>
</tr>
<tr>
<td>Data Source: University Hospital electronic medical record and business intelligence tools</td>
<td>Process Milestone 2 Estimated Incentive Payment: $528,315</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $411,855</td>
<td>Year 2 Estimated Outcome Amount: $411,855</td>
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<td>Year 3 Estimated Outcome Amount: $528,315</td>
</tr>
</tbody>
</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate
Unique RHP ID: 136141205.3.27 - PASS 3
Provider Name: University Hospital
TPI: 136141205

Outcome Measure Description:

Process Milestone 3
Develop and test data systems related to the identification of multiple hospitalization
Data Source:

Process Milestone 2
Establish baseline rates

Outcome measure:
3.IT-3.8
Reduction of readmission rate by TBD% by the end of DY5 for the target population

Rationale:

According to a 2009 American Hospital Association report approximately 18% of Medicare patients are readmitted within 30 days which costs the Medicare program approximately $15 billion a year. Legislators and regulators at all levels of government are exploring options for increasing quality and reducing health care costs related to avoidable readmissions. While not all readmissions are preventable understanding what is causing them and developing strategies to reduce readmissions can be implemented.

Case management services provided in the psychiatric emergency service can transition patients with multiple admissions over to community resources that can reduces reimbursement denials and preserves acute care beds for more appropriate admissions.

Outcome Measure Valuation:

By redirecting non emergent healthcare needs to community resources a reduction in readmissions to an inpatient stay will be supported while addressing a priority community need.

Valuation methodology for outcome measures and their associated process milestones included, for this project, assessment of relative value for breadth of impact on the project (in terms of the three criterion of numbers of patients affected, the large scope of the project, and the positive impact on the community).
<table>
<thead>
<tr>
<th>136141205.3.27 PASS 3</th>
<th>3.IT-3.8</th>
<th>Behavioral Health/Substance Abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
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<td>TPI - 136141205</td>
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**Related Category 1 or 2 Projects:**

136141205.1.10

**Starting Point/Baseline:**

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td></td>
</tr>
<tr>
<td>P-3 Develop and test data systems related to the identification of multiple hospitalization Data Source: University Hospital electronic medical record and business intelligence tools</td>
<td>[IT-3.8]: Reduce the BH/SA 30 day readmission rate by TBD% over baseline Improvement Target: Numerator- The number of readmissions, for patients 18 years and older, for any cause, within days of discharge for BH/SA admission. Denominator-The number of admissions, for patients 18 years and older, for patients discharged from the hospital for Behavioral Health/Substance Abuse and with a complete claims history for the 12 months prior to admission Data Source: Claims, encounter and clinical data</td>
<td>[IT-3.8]: Reduce the BH/SA 30 day readmission rate by TBD% over baseline Improvement Target: Numerator- The number of readmissions, for patients 18 years and older, for any cause, within days of discharge for Behavioral Health/Substance Abuse admission. Denominator-The number of admissions, for patients 18 years and older, for patients discharged from the hospital for Behavioral Health/Substance Abuse and with a complete claims history for the 12 months prior to admission</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>P-2 Establish baseline rates Data Source: University Hospital ER report</td>
<td></td>
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</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $528,315</td>
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<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $411,855</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Estimated Outcome Amount</td>
<td>Estimated Incentive Payment</td>
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<td></td>
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<tr>
<td>Year 2</td>
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<td>$884,203</td>
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</tr>
<tr>
<td>Year 3</td>
<td>$528,315</td>
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</tr>
<tr>
<td>Year 4</td>
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<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>$2,203,648</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,028,021**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-7.8 Chronic Disease Patients Accessing Dental Services *(Standalone measure)*
Unique RHP ID#: 136141205.3.28 – PASS 3
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider *(Standalone measure)*

Process Milestones:
Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3.

DY 2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY 3: P-2 Establish baseline rates for percentage of patients with a chronic disease conditions accessing dental health services following a referral by a medical provider.

Outcome Improvement Target for each year:

DY4: Improvement Target: Increase in chronic disease patients who access dental health services X% from baseline Y3

DY5: Improvement Target: Increase in chronic disease patients who access dental health services X% from baseline Y3

Rationale:
The rationale for selecting the following process milestones reflect the methodical approach that will be undertaken to engage stakeholders, identify required resources, develop an implementation, establish baseline performance measures and a project monitoring plan to ensure appropriate alignment with improving and reporting of data and systems that will provide the necessary infrastructure to ensure timely and accurate reporting of patient outcome measures (IT 7.8 Chronic Disease Patient Accessing Dental Services).

National studies on disparities in receipt of oral health services find that almost half of all Americans do not a visit a dentist each year and nearly one-third lack access to basic preventive and primary oral health care services. In addition, these studies further detail that Individuals who are least likely to access preventative oral health care are more likely to have higher rates of oral disease. In particular, economically vulnerable populations that include minority adults, persons with a chronic disease and children are significantly less likely to have access to oral health care compared to their non-poor and non-minority peers. Studies on adherence to
preventive oral health services find that patients are more likely to seek dental services when the importance of need is documented by a formal referral being made.

The target population will be economically vulnerable populations that seek services at UHS including Carelink members assigned to UHS patient centered medical homes. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

**Outcome Measure Valuation:**

This outcome will be valued based on the number of chronic disease patients that are able to access dental health services within the project timeframe. The rationale is implementing patient-centered care and leveraging resources with partners safety net providers allows for expanded comprehensive clinical preventive care, better care coordination, and improved health promotion and disease prevention.
### Chronic Disease Patients Accessing Dental Services

<table>
<thead>
<tr>
<th>Performing Provider Name: University Health System</th>
<th>TPI - 1316141205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>136141205.1.11</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
</tr>
</tbody>
</table>

#### Year 2
- **Process Milestone 1**
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans to support access and enhancement of dental health services.
  - Data Source: Meeting minutes, implementation plans, strategic planning reports.
  - Process Milestone 1 Estimated Incentive Payment: $102,149

#### Year 3
- **Process Milestone 2**
  - P-2 Establish baseline rates for patients with chronic disease accessing dental health services following referral by their medical provider.
  - Metric 1: Number of chronic disease patients who assess dental services following a referral.
  - Data Source: Sunrise, IDX, volume reports, quality reports
  - Process Milestone 2 Estimated Incentive Payment: $131,034

#### Year 4
- **Outcome Improvement Target 1**
  - IT-7.8 CD Patients Accessing Dental Services:
  - Improvement Target: Increase number of chronic disease patients who access dental health services following referral by medical provider X% from baseline Y3. TBD
  - Data Source: Sunrise, IDX, volume reports, quality reports
  - Outcome Improvement Target 1 Estimated Incentive Payment: $219,303

#### Year 5
- **Outcome Improvement Target 2**
  - IT-7.8 CD Patients Accessing Dental Services:
  - Improvement Target: Increase number of chronic disease patients who access dental health services following referral by medical provider X% from baseline Y3. TBD
  - Data Source: Sunrise, IDX, volume reports, quality reports
  - Outcome Improvement Target 2 Estimated Incentive Payment: $546,554

#### Year 2 Estimated Outcome Amount: $102,149
#### Year 3 Estimated Outcome Amount: $131,034
#### Year 4 Estimated Outcome Amount: $219,303
#### Year 5 Estimated Outcome Amount: $546,554

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $999,040**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate (Stand-Alone Measure)
Unique RHP ID#: 136141205.3.29– PASS 3
Performing Provider: University Hospital
TPI: 136141205

Outcome Measure Description:

Process Milestone

DY2
- P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.
  - Next steps will be to establish an Executive team for reporting efforts.
  - Prioritization of future process steps will be identified
  - Identification of the implementation team members and the subcommittees needed to accomplish the goals and priorities will be established.

DY3
- P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
  - Regularly scheduled meetings will be held to discuss successes and failures and determine future courses of action.

OD-3 Potentially Preventable Re-Admissions – 30 Day Readmission Rates (PPRs)
- IT-3.2 Congestive Heart Failure 30 day readmission rate (Stand-Alone Measure)
  - Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
  - Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal or secondary diagnosis of HF and with a complete claims history for the 12 months prior to admission.

Rationale:
The Potentially Preventable Admissions Outcome Measure enables the Transitions of Care Program to identify, monitor, and assess the patients placed on the CHF initiative. Data presented by TMF for 2010, reported a 30.1 readmission rate for Medicare Beneficiaries at University Hospital diagnosed with congestive heart failure. The RHP 6 average was 20.5 for the same population.
<table>
<thead>
<tr>
<th>Outcome Measure Valuation:</th>
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<tbody>
<tr>
<td>The project will value the outcome and measure success by the readmission rate for patients admitted with a diagnosis of heart failure (IT-3.2). With a more coordinated discharge process, patients will have a clearer follow-up timeline to manage their chronic condition. The investment in redesigning this process with more of a focus on post discharge planning and care coordination will avoid higher cost hospital stays for readmitted patients. This drives value to RHP 6 by directly addressing CN.2 which cites a need for better chronic disease management.</td>
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<tr>
<td>136141205.3.29 PASS 3</td>
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<tr>
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<td>Starting Point/Baseline:</td>
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<td><strong>Year 2</strong></td>
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<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
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<td>Data Source: Meeting minutes</td>
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**Estimated Incentive Payment:**

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<th>Year 5</th>
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<tr>
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<tr>
<td></td>
<td>$884,203</td>
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<td>$2,203,648</td>
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</table>

**Data Source:** IDX, Crimson, Truven Health

**Outcome Improvement Target**

- Year 2 Estimated Incentive Payment: $2,203,648

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,028,021
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%) | 233- NQF 0059 (Standalone measure) |
| Unique Category 3 Outcome RHP ID: 136141205.3.30 (Replaces 136141205.3.20) |
| Performing Provider: University Hospital |
| TPI: 136141205 |

### Outcome Measure Description:

| IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure) |

This measure will demonstrate whether patients are in control of the management of their diabetes during the implementation of the project.

- **Numerator:** Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- **Denominator:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).
- **Data Source:** EHR
- **Rationale/Evidence:** Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

### Process Milestones:

**DY2:**
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1
- P-2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.

**DY3:**
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinics 2 & 3
- P-2 Establish baseline rates for number of diabetic patients at clinic site 2 & 3 and at UHS.

### Outcome Improvement Targets for each year

**DY 4:** IT-10.1 Diabetes care: HbA1c poor control (>9.0%), Improvement Target: TBD Percent increase over baseline of the number of people with HbA1c <9% from the first year of implementation in site 1.

**DY 5:** IT-10.1 Diabetes care: HbA1c poor control (>9.0%), Improvement Target: TBD Percent increase over baseline of the number of people with HbA1c <9% from the first year of implementation in site 2 & 3.
### Rationale:
There is an abundance of evidence that the Chronic Care Model can be effectively implemented to help patients manage their diabetes and improve their overall outcomes through the partnership between the primary care teams and the patient. In DY2 and DY3 the primary care teams from all 3 sites require training by an endocrinologist in all aspects of specialty care for patients with low to moderate risk of complications. One site will complete training and full implementation of the program components by the end of DY2, and other sites will be fully trained and implemented by the end of DY3. Adherence to the medical recommendations will demonstrate the level of empowerment the patient experienced through the strength of the relationship with the primary care team. Further evidence of adherence to medical recommendations will be through monitoring of HbA1c test results.

### Outcome Measure Valuation:
In Bexar County 11.8% (137,009) have been diagnosed with diabetes, which is in vast contrast to 9.3% (1.7 million) diabetes in the state. Diabetes is also the 4th leading cause of death in Bexar County. In face of such high prevalence of diabetes in Bexar County, effective management is necessary to reduce the burden of the disease and the cost of treatment of complications. Texas has failed to meet the national standards for health care quality measures regarding diabetes. This innovative, evidence-based approach will increase help meet the three part CMS aim of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways, which translates to reducing the costs due to unnecessary hospitalizations and the treatment of complications related to poor control of diabetes. Each project site has been chosen because of the proximity to areas where the majority of UHS’ diabetic population reside. The efficacy of the program will be demonstrated through monitoring HbA1c test results.
<table>
<thead>
<tr>
<th>136141205.3.30</th>
<th>3.IT-10.1</th>
<th>Diabetes care: HbA1c poor control (&gt;9.0%) - NQF 0059 (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>University Hospital</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>136141205.2.10</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Process Milestone 3</td>
<td>Process Milestone 4</td>
</tr>
<tr>
<td>P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1</td>
<td>P-2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.</td>
<td>P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinics 2 &amp; 3</td>
<td>P-2 Establish baseline rates for number of diabetic patients at clinic site 2 &amp; 3 and at UHS.</td>
</tr>
<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: Sunrise, IDX, Quality reports</td>
<td>Data Source: Meeting minutes</td>
<td>Data Source: Sunrise, IDX, Quality reports</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $115,290</td>
<td>Year 3 Estimated Outcome Amount: $133,841</td>
<td>Year 4 Estimated Outcome Amount: $215,530</td>
<td>Year 5 Estimated Outcome Amount: $514,772.33</td>
</tr>
</tbody>
</table>
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $979,433.33
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): | IT-1.11 BP control (<140/80mm Hg) – NQF 0061 (Standalone measure) |
| Unique Category 3 Outcome RHP ID: | 136141205.3.31 (Replaces 136141205.3.20) |
| Performing Provider: | University Hospital |
| TPI: | 136141205 |

**Outcome Measure Description:**

This measure will demonstrate whether patients are in control of the management of their diabetes during the implementation of the project.

**IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (Standalone measure)**

| a Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. |
| b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) |
| c Data Source: EHR, Registry, Claims, Administrative clinical data |
| d Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented or delayed through appropriate management. |

**Process Milestones:**

**DY2:**
- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1
- P- 2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.

**DY3:**
- P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinics 2 & 3.
- P-2 Establish baseline rates for number of diabetic patients at clinic site 2 & 3 and at UHS.

**Outcome Improvement Targets for each year**

**DY 4:**
- IT-11.1 Diabetes care: BP control (<140/80mm Hg), Improvement Target: TBD Percent increase over baseline of the number of people with BP measures <140/80mm Hg during the first year of implementation in site 1.

**DY 5:**
- IT-11.1 Diabetes care: BP control (<140/80mm Hg), Improvement Target: TBD Percent increase over baseline of the number of people with BP measures <140/80mm Hg during the first year of implementation in sites 2 & 3.

**Rationale:**

There is an abundance of evidence that the Chronic Care Model can be effectively implemented to help patients manage their diabetes and improve their overall outcomes through the
partnership between the primary care teams and the patient. In DY2 and DY3 the primary care teams from all 3 sites require training by an endocrinologist in all aspects of specialty care for patients with low to moderate risk of complications. One site will complete training and full implementation of the program components by the end of DY2, and other sites will be fully trained and implemented by the end of DY3. Adherence to the medical recommendations will demonstrate the level of empowerment the patient experienced through the strength of the relationship with the primary care team. Further evidence of adherence to medical recommendations will be through monitoring of blood pressures which are within the established guidelines for diabetic patients.

**Outcome Measure Valuation:**

In Bexar County 11.8% (137,009) have been diagnosed with diabetes, which is in vast contrast to 9.3% (1.7 million) diabetes in the state. Diabetes is also the 4th leading cause of death in Bexar County. In face of such high prevalence of diabetes in Bexar County, effective management is necessary to reduce the burden of the disease and the cost of treatment of complications. Texas has failed to meet the national standards for health care quality measures regarding diabetes. This innovative, evidence-based approach will increase help meet the three part CMS aim of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways, which translates to reducing the costs due to unnecessary hospitalizations and the treatment of complications related to poor control of diabetes.

Each project site has been chosen because of the proximity to areas where the majority of UHS’ diabetic population reside. The efficacy of the program will be demonstrated through monitoring of blood pressures which are within the established guidelines for diabetic patients.
<table>
<thead>
<tr>
<th>136141205.3.31</th>
<th>3.IT-1.11</th>
<th>Diabetes care: BP control (&lt;140/80mm Hg) – NQF 0061 (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces 136141205.3.20</td>
<td>University Hospital</td>
<td>TPI - 136141205</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>136141205.2.10</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be developed in DY3</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1</td>
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</tr>
<tr>
<td>P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1</td>
<td>P- 2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.</td>
<td>P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinics 2 &amp; 3</td>
</tr>
<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: Sunrise, IDX, Quality reports</td>
<td>Data Source: Meeting minutes</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $57,645</td>
<td>Process Milestone 2 Estimated Incentive Payment: $57,645</td>
<td>Process Milestone 1 Estimated Incentive Payment: $66,920.50</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $115,290</td>
<td>Year 3 Estimated Outcome Amount: $153,841</td>
<td>Year 4 Estimated Outcome Amount: $215,530</td>
</tr>
<tr>
<td>Outcome Improvement Target 2</td>
<td>1 Estimated Incentive Payment: $215,530</td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $979,433.33</td>
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</tr>
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</table>

1342 ★ RHP 6 Plan ★ March 8, 2013 University Hospital
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>3.IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Category 3 Outcome RHP ID:</td>
<td>136141205.3.32 (Replaces 136141205.3.20)</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>University Hospital</td>
</tr>
<tr>
<td>TPI</td>
<td>136141205</td>
</tr>
</tbody>
</table>

## Outcome Measure Description:

### 3.IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)

**a** Numerator: Number of patients who had each of the following during the reporting period:
- Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
- LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

**b** Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year.

**c** Data Source: EHR, Registry

**d** Rationale/Evidence: Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque.

Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%.

The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100

### Process Milestones:

**DY2:** P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1
P- 2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.
**DY3:** P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinics 2 & 3

P-2 Establish baseline rates for number of diabetic patients at clinic site 2 & 3 and at UHS

**Outcome Improvement Targets for each year**

**DY 4:** IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS2012) *(Standalone measure)*, Improvement Target: TBD Percent increase over baseline of the number of people with LDL-C Level Less Than 100 mg/dL from the first year of implementation in site 1.

**DY 5:** IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS2012) *(Standalone measure)*, Improvement Target: TBD Percent increase over baseline of the number of people with LDL-C Level Less Than 100 mg/dL from the first year of implementation in sites 2 & 3.

**Rationale:**

There is an abundance of evidence that the Chronic Care Model can be effectively implemented to help patients manage their diabetes and improve their overall outcomes through the partnership between the primary care teams and the patient. In DY2 and DY3 the primary care teams from all 3 sites require training by an endocrinologist in all aspects of specialty care for patients with low to moderate risk of complications. One site will complete training and full implementation of the program components by the end of DY2, and other sites will be fully trained and implemented by the end of DY3. Adherence to the medical recommendations will demonstrate the level of empowerment the patient experienced through the strength of the relationship with the primary care team. Further evidence of adherence to medical recommendations will be through monitoring of LDL test results as established by the recommended guidelines.

**Outcome Measure Valuation:**

In Bexar County 11.8% (137,009) have been diagnosed with diabetes, which is in vast contrast to 9.3% (1.7 million) diabetes in the state. Diabetes is also the 4th leading cause of death in Bexar County. In face of such high prevalence of diabetes in Bexar County, effective management is necessary to reduce the burden of the disease and the cost of treatment of complications. Texas has failed to meet the national standards for health care quality measures regarding diabetes. This innovative, evidence-based approach will increase help meet the three part CMS aim of assuring patients receive high-quality, patient-centered care, in the most cost-effective ways, which translates to reducing the costs due to unnecessary hospitalizations and the treatment of complications related to poor control of diabetes.

Each project site has been chosen because of the proximity to areas where the majority of UHS’ diabetic population reside. The efficacy of the program will be demonstrated through monitoring of LDL test results as established by the recommended guidelines.
<table>
<thead>
<tr>
<th>136141205.3.32</th>
<th>3.IT-1.6</th>
<th>Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) <em>(Standalone measure)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>136141205.2.10</td>
<td>TPI - 136141205</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>To be developed in DY2</td>
</tr>
<tr>
<td></td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

**Process Milestone 1**
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for clinic 1

Data Source: Meeting minutes

Process Milestone 1 Estimated Incentive Payment: $57,645

**Process Milestone 2**
P- 2 Establish baseline rates for number of diabetic patients at clinic site 1 and at UHS.

Data Source: Sunrise, IDX, Quality reports

Process Milestone 2 Estimated Incentive Payment: $57,645

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**Outcome Improvement Target 1**
IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS2012) *(Standalone measure)*

Improvement Target: TBD

Percent increase over baseline of the number of people with LDL-C Level Less Than 100 mg/dL from the first year of implementation in site 1.

Data Source: EMR

Outcome Improvement Target 1 Estimated Incentive Payment: $215,530

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**Outcome Improvement Target 2**
IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS2012) *(Standalone measure)*

Improvement Target: TBD

Percent increase over baseline of the number of people with LDL-C Level Less Than 100 mg/dL from the first year of implementation in sites 2 & 3.

Data Source: EMR

Outcome Improvement Target 2 Estimated Incentive Payment: $514,772.33
<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $115,290</th>
<th>Year 3 Estimated Outcome Amount: $133,841</th>
<th>Year 4 Estimated Outcome Amount: $215,530</th>
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<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $979,433.33</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-3.1: All Cause 30 Day Readmission Rate- NQF 1789 (stand-alone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number(s):</td>
<td>121782003.3.1 - PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Uvalde Memorial Hospital</td>
</tr>
<tr>
<td>TPI:</td>
<td>121782003</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

IT-3.1: All Cause 30 Day Readmission Rate- NQF 1789 (stand-alone)

A readmission will be defined as an inpatient admission to any acute care facility which occurs within 30 days of discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. The readmission rate will be calculated out of the number of admissions to acute care facilities for patients aged 65 years or older.

**Process Milestones:**

- **DY 2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY 3:**
  - P-3 – Develop and test data systems
  - P-2 – Establish baseline rates

**Outcome Improvement Target(s):**

- **DY 4:**
  - IT-3.1 All Cause 30 Day Readmission Rate- NQF 1789 (stand-alone)
    - Percent reduction in the all cause 30 day readmission rate will be determined after P-3.2 is achieved in DY 3.

- **DY 5:**
  - IT-3.1 All Cause 30 Day Readmission Rate- NQF 1789 (stand-alone)
    - Percent reduction in the all cause 30 day readmission rate will be determined after P-3.2 is achieved in DY 3.

**Rationale:**

Process milestones (P-1 through P-3) were chosen due to the current lack of accurate reports, resources and systems necessary for monitoring, measuring and reporting all cause 30 day readmission rates. In DY 2 P-1 was chosen to develop plans and garner staff support while P-2 and P-3 will allow accurate systems and a valid baseline. The accomplishment of these milestones will allow for percentage improvements to be determined for DY 4 and DY 5 in the outcome improvement target: IT-3.1 All Cause 30 Day Readmission Rate- NQF 1789 (stand-alone).
Outcome Measure Valuation:
The outcome measure chosen with its associated process milestones and outcome improvement targets, are those with the highest potential for impact on the physical and financial health of the population.

Methods used to value and select the outcome measure hinged on a valuation methodology including the following four categories: Achieves Waiver Goals, Addresses Community Need(s), Project Scope and Project Investment.

Reducing the all-cause 30 day readmissions rate is achieved through case management and increased follow-up. When patients are regularly followed up with, they are more likely to follow their discharge instructions, take their medications, and make it to appointments with their physicians. This increases the health of patients, especially those who are elderly and prone to readmission.

From a cost avoidance perspective, reducing potentially preventable re-admissions will reduce cost with each decrease in re-admission in DY 4 and DY 5. From the patient perspective, costs are avoided and health increases, especially when one considers the rate of hospital acquired infections increases with each re-admission.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>[P-3]: Develop and test data systems. Data Source: EMR system reports, quality/information department reports.</td>
<td>[P-2]: Establish baseline rates. Data Source: EMR system, Claims, patient records, other documentation sources.</td>
<td>[IT-3.1]: All cause 30-day readmission rate- NQF 1789 (stand-alone) Improvement Target: Percent reduction in the all cause 30 day readmission rate will be determined after P-3.2 is achieved in DY 3. Data Source: EMR, Claims.</td>
<td>[IT-3.1]: All cause 30-day readmission rate- NQF 1789 (stand-alone) Improvement Target: Percent reduction in the all cause 30 day readmission rate will be determined after P-3.2 is achieved in DY 3. Data Source: EMR, Claims.</td>
</tr>
<tr>
<td>Data Source: Documentation of meetings held, attendance sheets and documented recommendations. Process Milestone 1 Estimated Incentive Payment: $119,694</td>
<td>Process Milestone 2 Estimated Incentive Payment: $69,370.5</td>
<td>Process Milestone 3 Estimated Incentive Payment: $69,370.5</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $222,631</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $532,378</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $119,694  
Year 3 Estimated Outcome Amount: $138,741  
Year 4 Estimated Outcome Amount: $222,631  
Year 5 Estimated Outcome Amount: $532,378

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,013,445**
**Identifying Outcome Measure and Provider Information:**

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization (stand-alone)
Unique RHP outcome identification number: 121782003.3.2 – PASS 1
Performing Provider: Uvalde Memorial Hospital
TPI: 121782003

**Outcome Measure Description:**

IT-9.2 ED appropriate utilization (stand-alone): Reduce ED visits for target conditions

Target conditions include: Congestive Heart Failure, Diabetes, Cardiovascular Disease/Hypertension, and Chronic Obstructive Pulmonary Disease.

**Process Milestones:**

- **DY 2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY 3:**
  - P-3 – Develop and test data systems
  - P-2 – Establish baseline rates

**Outcome Improvement Target(s):**

- **DY 4:**
  - ED appropriate utilization (stand-alone): Reduce ED visits for target conditions
    - Percent reduction in the number of ED visits for target conditions will be determined after P-3.2 is achieved in DY 3.

- **DY 5:**
  - ED appropriate utilization (stand-alone): Reduce ED visits for target conditions
    - Percent reduction in the number of ED visits for target conditions will be determined after P-3.2 is achieved in DY 3.

**Rationale:**

Process milestones (P-1 through P-3) were chosen due to the current lack of accurate reports, resources and systems necessary for monitoring, measuring and reporting ED admissions for target conditions. In DY 2 P-1 was chosen to develop plans and garner staff support while P-2 and P-3 will allow accurate systems and a valid baseline.

Accomplishing these milestones will allow for percentage improvements to be determined for DY 4 and DY 5 in the outcome improvement target: IT-9.2 ED appropriate utilization (stand-alone): Reduce ED visits for target conditions.

Specific improvement targets for each target condition will be determined in DY 3 after the accomplishment of [P-3.2]. These target conditions were selected as they are the most likely to be impacted by the linked Category 1 project, 121782003.1.1 in areas of: cost, patient education, and quality of care. Specifically, case management and community health worker programs have been linked to reductions in admissions for these target conditions in many hospitals throughout the country.
**Outcome Measure Valuation:**

The outcome measure chosen with its associated process milestones and outcome improvement targets, are those with the highest potential for impact on the physical and financial health of the population.

Methods used to value and select the outcome measure hinged on a valuation methodology including the following four categories: Achieves Waiver Goals, Addresses Community Need(s), Project Scope and Project Investment.

Reducing ED admissions for target conditions is achieved through case management and increased follow-up. When patients are regularly followed up with, they are more likely to follow their discharge instructions, take their medications, and make it to appointments with their physicians. This increases the health of patients, especially those who are elderly and prone to readmission.

From a cost avoidance perspective, reducing ED visits will reduce hospital and payer cost as the ED is the highest source of uninsured and Medicaid admissions. From the patient perspective, costs are avoided and health increases, as care is shifted from the ED to primary care.
<table>
<thead>
<tr>
<th>Project 121782003.3.2</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization (stand-alone)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PASS 1</strong></td>
<td></td>
<td><strong>Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital</strong></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects: 1.2</td>
<td>121782003.1.1</td>
<td><strong>TPI - 121782003</strong></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td><strong>TBD</strong></td>
</tr>
</tbody>
</table>
| **Process Milestone 1** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2** [P-3]: Develop and test data systems
Data Source: EMR system reports, quality/information department reports. | **Outcome Improvement Target 1**
[IT-9.2]: ED appropriate utilization: Reduce ED visits for target conditions
Data Source: EMR, Claims
Outcome Improvement Target 1 Estimated Incentive Payment: $222,631 |
| Data Source: Documentation of meetings held, attendance sheets and documented recommendations. Process Milestone 1 Estimated Incentive Payment: $119,694 | **Process Milestone 3** [P-2]: Establish baseline rates
Data Source: EMR system, Claims, patient records, other documentation sources | **Outcome Improvement Target 2**
[IT-9.2]: ED appropriate utilization: Reduce ED visits for target conditions
Data Source: EMR, Claims
Outcome Improvement Target 2 Estimated Incentive Payment: $532,378 |
<p>| Year 2 Estimated Outcome Amount: $119,694 | Year 3 Estimated Outcome Amount: $138,741 | Year 4 Estimated Outcome Amount: $222,631 |
| Year 5 Estimated Outcome Amount: $532,378 | <strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,013,445</strong> |
| Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |
| Year 3 Estimated Outcome Amount: $138,741 | Year 4 Estimated Outcome Amount: $222,631 |
| Year 5 Estimated Outcome Amount: $532,378 | |</p>
<table>
<thead>
<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Outcome Measure (Improvement Target): IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</td>
</tr>
<tr>
<td>Unique RHP outcome identification number(s): 121782003.3.3 – PASS 2</td>
</tr>
<tr>
<td>Provider Name: Uvalde Memorial Hospital</td>
</tr>
<tr>
<td>TPI: 121782003</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome Measure Description:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</td>
</tr>
<tr>
<td>• Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life (stand-alone measure).</td>
</tr>
<tr>
<td>o Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life</td>
</tr>
<tr>
<td>o Denominator: Patients who died from cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Process Milestones:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>DY 2:</strong></td>
</tr>
<tr>
<td>o P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
</tr>
<tr>
<td>• <strong>DY 3:</strong></td>
</tr>
<tr>
<td>o P-3 – Develop and test data systems</td>
</tr>
<tr>
<td>o P-2 – Establish baseline rates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome Improvement Target(s):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>DY 4:</strong></td>
</tr>
<tr>
<td>o Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</td>
</tr>
<tr>
<td>▪ Percent reduction in the number of patient who died from cancer and were admitted to the ICU in their last 30 days of life will be determined after P-2 is achieved in DY 3.</td>
</tr>
<tr>
<td>• <strong>DY 5:</strong></td>
</tr>
<tr>
<td>o Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</td>
</tr>
<tr>
<td>▪ Percent reduction in the number of patient who died from cancer and were admitted to the ICU in their last 30 days of life will be determined after P-2 is achieved in DY 3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rationale:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Process milestones (P-1 through P-3) were chosen due to the current lack of accurate reports, resources and systems necessary for monitoring, measuring and reporting palliative care consults. In DY 2 P-1 was chosen to develop plans and garner staff support while P-2 and P-3 will allow accurate systems and a valid baseline.</td>
</tr>
<tr>
<td>Accomplishing these milestones will allow for percentage improvements to be determined for DY 4 and DY 5 in the outcome improvement target: IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213).</td>
</tr>
<tr>
<td>Specific improvement targets for each target condition will be determined in DY 3 after the accomplishment of [P-3.2]. These target conditions were selected as they are the most likely to be impacted by the linked Category 1 project, 121782003.2.1 in areas of: cost, patient education, and quality of care. Specifically, palliative care programs have been linked to reductions in ICU admissions in the last 30 days of life at many hospitals throughout the country.</td>
</tr>
</tbody>
</table>
**Outcome Measure Valuation:**

The outcome measure chosen with its associated process milestones and outcome improvement targets, are those with the highest potential for impact on the physical and financial health of the population. Methods used to value and select the outcome measure hinged on a valuation methodology including the following four categories: Achieves Waiver Goals, Addresses Community Need(s), Project Scope and Project Investment. Uvalde Memorial Hospital also values each outcome based on the following factors: the potential impact on health of our population, the resources necessary to achieve the outcome, and level of improvement anticipated in overall patient satisfaction.

From a cost avoidance perspective, reducing ICU admissions during the last 30 days of life will reduce hospital and payer cost as the ICU is a very high cost source for care. Not only are ICU stays for these patients expensive for their families, they are also not comfortable or accommodating to the needs of the patient and his or her family. Costs are avoided, and pain managed more effectively during the last days of life through an effective palliative care program that puts the needs of the patient and family first.
<table>
<thead>
<tr>
<th>121782003.3.3 PASS 2</th>
<th>3.IT-13.4</th>
<th>Proportion admitted to the ICU in the last 30 days of life (NQF 0213)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital</td>
<td>121782003.2.1</td>
<td>TPI - 121782003</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects: 1.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-3]: Develop and test data systems Data Source: EMR system reports, quality/information department reports.</td>
<td>Outcome Improvement Target 1 [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life (NQF 0213) Improvement Target: Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. (stand-alone) Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life Denominator: Patients who died from cancer Baseline: Established in DY 3 by accomplishment of P-2 Goal: Percentage reduction or improvement determined in DY 3 after accomplishment of P-2 Data Source: EMR, Palliative care database Outcome Improvement Target 1 Estimated Incentive Payment: $119,181</td>
</tr>
<tr>
<td>Process Milestone 3 [P-2]: Establish baseline rates Data Source: EMR system, Claims, patient records, other documentation sources</td>
<td>Process Milestone 2 Estimated Incentive Payment: $37,005</td>
<td>Year 2 Estimated Outcome Amount: $63,752</td>
</tr>
<tr>
<td>Data Source: Documentation of meetings held, attendance sheets and documented recommendations. Process Milestone 1 Estimated Incentive Payment: $63,752</td>
<td>Year 3 Estimated Outcome Amount: $74,010</td>
<td>Year 4 Estimated Outcome Amount: $119,181</td>
</tr>
<tr>
<td></td>
<td>Year 2 Estimated Outcome Amount: $63,752</td>
<td>Year 3 Estimated Outcome Amount: $74,010</td>
</tr>
</tbody>
</table>
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $541,597
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): 6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP ID: 119877204.3.1 – PASS 1
Performing Provider: Val Verde Regional Medical Center (VVRMC)
TPI: 119877204

Outcome Measure Description:

In DY2 & 3, VVRMC will accomplish Process Milestones as listed below in regards to developing the processes and foundation for its clinic patient experience program.

Process Milestones
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
P-2 Establish baseline rates – DY 3

Improvement Target
In DY 4 & 5, VVRMC has selected the following Improvement Target and given success in DY 2 & 3 for accomplishing its Process Milestones will be in good position to achieve improvements in patient experience:

OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. VVRMC will capture data on each of the following elements:
(1) are getting timely care, appointments, and information; (Standalone measure)

a Numerator: Percent improvement in targeted patient satisfaction domain
b Data Source: Patient survey
c Denominator: Number of patients who were administered the survey

Rationale:
The bell-weather metric for measuring patient experience is patient satisfaction. As VVRMC works to expand access to care in its rural community, it becomes important to measure and assure success in regards to the ease of access and interaction with the providers in the clinics. The community needs assessment clearly identified bringing additional healthcare resources to Val Verde County as a high priority. In addition, the expectation is that the providers will be set-up and organized well to be able to meet everyone’s expectations around how they receive care. It is our intent in the first two DY’s to establish a process, similar to how we measure on the inpatient side of services, that will afford all of the clinics baseline data. In DY 4 & 5 patient satisfaction will be formally measured and compared back to baseline years to demonstrate improvements in how care is perceived at the clinics.

The intent of this initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinic care. The surveys are designed to
produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Outcome Measure Valuation:**

The outcome measure selected, with its associated improvement target, was chosen based on how accurately it demonstrates patient impact and benefit. The following valuation methodology suggested by the Anchor was also taken into consideration. How does the project achieve waiver goals? Does it address community needs sufficiently? What is the scope of the project/outcome? What is the total project/outcome investment? Based on this criteria and potential patient impact/benefit, improving patient satisfaction was selected as our Category 3 outcome measure and improvement target.

Continually working to improve patient satisfaction at primary care and specialty care clinics, as well as through our telemedicine program, will improve the quality of healthcare provided in our region. It is the only measure within the RHP planning protocol that ensures care is truly “patient-centered” and meets the waiver goals.

If we are able to demonstrate very high patient satisfaction with the new services provided through the clinics, we will have met Val Verde County and Del Rio’s expectations in regards to what was important to them through community needs assessments.

This will be a significant undertaking as there currently is no formal process for measuring satisfaction in the clinic locations.

This outcome measure will impact thousands of citizens in the community, as all that interact in the primary care and specialty clinics will be asked for their feedback.
<table>
<thead>
<tr>
<th>119877204.3.1</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Val Verde Regional Medical Center</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>119877204.1.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Data Source: Internal documents</td>
<td>Data Source: 3rd party data source (e.g. Gallup)</td>
<td>Data Source: 3rd party data source (e.g. Gallup)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $120,123</td>
<td>Process Milestone 2 Estimated Incentive Payment: $139,238</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $223,429</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $120,123</td>
<td>Year 3 Estimated Outcome Amount: $139,238</td>
<td>Year 4 Estimated Outcome Amount: $223,429</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $534,286</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,017,076
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-6.1 Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID:</td>
<td>119877204.3.2 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Val Verde Regional Medical Center (VVRMC)</td>
</tr>
<tr>
<td>TPI:</td>
<td>119877204</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

In DY2 & 3, VVRMC will accomplish Process Milestones as listed below in regards to developing the processes and foundation for its clinic patient experience program.

**Process Milestones**

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
- P-2 Establish baseline rates – DY 3

**Improvement Target**

In DY 4 & 5, VVRMC has selected the following Improvement Target and given success in DY 2 & 3 for accomplishing its Process Milestones will be in good position to achieve improvements in patient experience:

**OD-6 Patient Satisfaction**

**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. VVRMC will capture data on each of the following elements:

1. (Standalone measure)
   - Numerator: Percent improvement in targeted patient satisfaction domain
   - Data Source: Patient survey
   - Denominator: Number of patients who were administered the survey

**Rationale:**

The bell-weather metric for measuring patient experience is patient satisfaction. As VVRMC works to expand access to care in its rural community, it becomes important to measure and assure success in regards to the ease of access and interaction with the providers in the clinics. The community needs assessment clearly identified bringing additional healthcare resources to Val Verde County as a high priority. In addition, the expectation is that the providers will be set-up and organized well to be able to meet everyone’s expectations around how they receive care. It is our intent in the first two DYs to establish a process, similar to how we measure on the inpatient side of services, that will afford all of the clinics baseline data. In DY 4 & 5 patient satisfaction will be formally measured and compared back to baseline years to demonstrate improvements in how care is perceived at the clinics.

The intent of this initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on clinic care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and
meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

**Outcome Measure Valuation:**

The outcome measure selected, with its associated improvement target, was chosen based on how accurately it demonstrates patient impact and benefit. The following valuation methodology suggested by the Anchor was also taken into consideration. How does the project achieve waiver goals? Does it address community needs sufficiently? What is the scope of the project/outcome? What is the total project/outcome investment? Based on this criteria and potential patient impact/benefit, improving patient satisfaction was selected as our Category 3 outcome measure and improvement target.

Continually working to improve patient satisfaction at primary care and specialty care clinics, as well as through our telemedicine program, will improve the quality of healthcare provided in our region. It is the only measure within the RHP planning protocol that ensures care is truly “patient-centered” and meets the waiver goals.

If we are able to demonstrate very high patient satisfaction with the new services provided through the clinics, we will have met Val Verde County and Del Rio’s expectations in regards to what was important to them through community needs assessments.

This will be a significant undertaking as there currently is no formal process for measuring satisfaction in the clinic locations.

This outcome measure will impact thousands of citizens in the community, as all that interact in the primary care and specialty clinics will be asked to participate and for their feedback.
<table>
<thead>
<tr>
<th>119877204.3.2 PASS 1</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Val Verde Regional Medical Center</td>
<td>TPI - 119877204</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 P-1 Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Internal documents Process Milestone 1 Estimated Incentive Payment: $120,123</td>
<td>Process Milestone 2 P-2 – Establish baseline rates Data Source: 3rd party data source (e.g. Gallup) Process Milestone 2 Estimated Incentive Payment: $139,238</td>
<td>Outcome Improvement Target 1 [IT-6.1]: Improvement Target TBD Data Source: 3rd party data source (e.g. Gallup) Outcome Improvement Target 1 Estimated Incentive Payment: $223,429</td>
<td>Outcome Improvement Target 2 [IT-6.1]: Improvement Target TBD Data Source: 3rd party data source (e.g. Gallup) Outcome Improvement Target 2 Estimated Incentive Payment: $534,286</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $120,123</td>
<td>Year 3 Estimated Outcome Amount: $139,238</td>
<td>Year 4 Estimated Outcome Amount: $223,429</td>
<td>Year 5 Estimated Outcome Amount: $534,286</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,017,076
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-6.1 - Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Outcome Number:</td>
<td>119877204.3.3 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Val Verde Regional Medical Center (VVRMC)</td>
</tr>
<tr>
<td>TPI:</td>
<td>119877204</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

In DY2 & 3, VVRMC will accomplish Process Milestones as listed below in regards to developing the processes and foundation for its telemedicine patient experience program.

#### Process Milestones

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – DY 2
- P-2 Establish baseline rates – DY 3

#### Improvement Milestones

In DY 4 & 5, VVRMC has selected the following Improvement Target and given success in DY 2 & 3 for accomplishing its Process Milestones will be in good position to achieve improvements in patient experience:

**OD-6 Patient Satisfaction**

**IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. VVRMC will capture data on each of the following elements:

1. Numerator: Percent improvement in targeted patient satisfaction domain
2. Data Source: Patient survey
3. Denominator: Number of patients who were administered the survey

#### Rationale:

The bell-weather metric for measuring patient experience is patient satisfaction. As VVRMC works to expand access to care in its rural community, it becomes important to measure and assure success in regards to the ease of access and interaction with the providers in through new technology of telemedicine. The community needs assessment clearly identified bringing additional healthcare resources to Val Verde County as a high priority. In addition, the expectation is that the providers will be set-up and organized well to be able to meet everyone’s expectations around how they receive care. It is our intent in the first two DYs to establish a process, similar to how we measure on the inpatient side of services, that will afford all the unique practice of telemedicine baseline data. In DY 4 & 5 patient satisfaction will be formally measured and compared back to baseline years to demonstrate improvements in how care is perceived through telemedicine.

The intent of this initiative is to provide a standardized survey instrument and data collection.
methodology for measuring patients' perspectives on telemedicine care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

<table>
<thead>
<tr>
<th>Outcome Measure Valuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The outcome measure selected, with its associated improvement target, was chosen based on how accurately it demonstrates patient impact and benefit. The following valuation methodology suggested by the Anchor was also taken into consideration. How does the project achieve waiver goals? Does it address community needs sufficiently? What is the scope of the project/outcome? What is the total project/outcome investment? Based on this criteria and potential patient impact/benefit, improving patient satisfaction was selected as our Category 3 outcome measure and improvement target.</td>
</tr>
</tbody>
</table>

Continually working to improve patient satisfaction at primary care and specialty care clinics, as well as through our telemedicine program, will improve the quality of healthcare provided in our region. It is the only measure within the RHP planning protocol that ensures care is truly "patient-centered" and meets the waiver goals.

If we are able to demonstrate very high patient satisfaction with the new services provided through telemedicine, we will have met Val Verde County and Del Rio’s expectations in regards to what was important to them through community needs assessments.

This will be a significant undertaking as there currently is no formal process for measuring satisfaction specifically for this new service.

This outcome measure will impact the citizens in the community, as all that interact with the telemedicine technology will be asked to participate and for their feedback.
<table>
<thead>
<tr>
<th>PASS 2</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Val Verde Regional Medical Center</td>
<td>TPI - 119877204</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>119877204.1.3</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 P-1 Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 P-2 – Establish baseline rates Data Source: 3rd party data source (e.g. Gallup) Process Milestone 2 Estimated Incentive Payment: $74,275</td>
<td>Outcome Improvement Target 1 [IT-6.1]: Improvement Target TBD Data Source: 3rd party data source (e.g. Gallup) Outcome Improvement Target 1 Estimated Incentive Payment: $119,609</td>
<td>Outcome Improvement Target 2 [IT-6.1]: Improvement Target TBD Data Source: 3rd party data source (e.g. Gallup) Outcome Improvement Target 2 Estimated Incentive Payment: $285,674</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $63,980</td>
<td>Data Source: Internal documents</td>
<td>Year 2 Estimated Outcome Amount: $63,980</td>
<td>Year 3 Estimated Outcome Amount: $74,275</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 4 Estimated Outcome Amount: $119,609</td>
<td>Year 5 Estimated Outcome Amount: $285,674</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $543,538**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#: 092414401.3.1 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider: Community Medicine Associates</td>
</tr>
<tr>
<td>TPI: 092414401</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**IT-9.2 ED appropriate utilization (Standalone measure)**

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3. After baseline established, goals will be set for outcomes measure in DY 4 and DY5.

Process Milestones:

**DY2:**
- P-1 – Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans.

**DY3:**
- P-2- Establish baseline rates for reduction in ED visits for targeted conditions

**Outcome Improvement Targets for each year:**

**DY4:**
- Reduce ED visits for targeted conditions by a TBD percentage from baseline Y3.

**DY5:**
- Reduce ED visits for targeted conditions by a TBD percentage from baseline Y3.

### Rationale:

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The targeted population will be the Carelink members assigned to University Health System patient centered medical homes. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.

Process Milestones P1 and P2 were chosen to allow time for necessary project planning and data
collection activities to understand our patients who will benefit the most from expanded primary care into their neighborhoods. It will also allow us to set up the necessary processes to effectively reach out and work with chronic disease patient as we expand our primary care capacity.

The improvement targets of reducing avoidable ED visits for specific medical conditions selected because of the evidence base associated with access to primary care and the reduction of unnecessary ED visits. Having a regular source of primary care increases the probability that patients with chronic medical conditions will have less exacerbations, better control of their disease, and therefore fewer ED visits caused by uncontrolled symptoms. Since this is an expansion of primary care in an existing patient population we know which patients to target for more outreach, and care management to reach our goals.

**Outcome Measure Valuation:**

This outcome will be valued based on the number of emergency visits avoided by patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma. The rational is expanded primary care and acute care through University Health System’s ExpressMed clinics will support patients in controlling these chronic conditions and reduce avoidable emergency center visits. It will also support the achievement of Waiver goals: a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
<table>
<thead>
<tr>
<th>092414401.3.1 PASS 2</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Medicine Associates</td>
<td>TPI - 092414401</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>092414401.1.1</td>
<td></td>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data Source: Meeting minutes</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-2 Establish baseline rates for reduction in ED visits for targeted conditions&lt;br&gt;Data Source: Sunrise, IDX, volume reports, Quality reports&lt;br&gt;Metric 1: Number of annual ER visits for CareLink patients with COPD, behavioral health, diabetes and asthma.&lt;br&gt;Metric 2: Number of avoidable ER visits for CareLink patients with these medical conditions</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Improvement Target: Reduce ED visits for targeted conditions by X% from baseline Y3. - TBD&lt;br&gt;Data Source: Quality, Sunrise, volume reports&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $339,611</td>
<td><strong>Outcome Improvement Target 3</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Improvement Target: Reduce ED visits for targeted conditions - by X% from baseline Y3. TBD&lt;br&gt;Data Source: Quality, Sunrise, volume reports&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $491,592</td>
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</table>

<table>
<thead>
<tr>
<th>Process Milestone 1 Estimated Incentive Payment:</th>
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<th>Process Milestone 2 Estimated Incentive Payment:</th>
<th>$210,893</th>
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<tr>
<th>Year 2 Estimated Outcome Amount:</th>
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<thead>
<tr>
<th>Year 4 Estimated Outcome Amount:</th>
<th>$339,611</th>
<th>Year 5 Estimated Outcome Amount:</th>
<th>$491,592</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,042,096**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-2.13 Other Admissions Rate
Unique RHP ID#: 092414401.3.2 – PASS 2
Performing Provider: Community Medicine Associates
TPI: 092414401

Outcome Measure Description:

OD – 2 Potentially Preventable Admissions

- IT 2.13 Other Admissions Rate (Stand-Alone Measure)
  - Numerator: Admissions to hospital of patients for Care Team
  - Denominator: Active panel of patients for Care Team
  - Data Source: EMR/IDX/Crimson/Truven Health/Allscripts

Process Milestone
DY2

- P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.
  - DY2 will be the year used to identify the appropriate personnel to discuss the Care management Model, to engage those identified individuals, determine the resources needed for a successful implementation, as well as the development of an implementation plan.
  - Preliminary stakeholders include executive leadership from ambulatory and acute, clinic providers and other clinic personnel, along with members of the care management team.
  - Once identified, the stakeholders will be actively engaged through regular meetings. The meetings will be an opportunity to show successes and discuss opportunities for improvement.

DY3

- P-2 Establish baseline rates
  - Care Coordination and clinic leadership will review all data associated with admissions, readmissions, and EC visits per clinic and identify the population(s) having high risk health care needs for management.

Outcome Improvement Target

DY4/5

- IT-2.13 Other Admissions Rate (Stand-Alone Measure)
  - The selection of Outcome Improvement Target 2.13 was based on the inability to identify a single diagnosis within a clinic panel in need of additional resources
and support. As high risk stratification criteria are developed, the intent of the Care Management Model is to improve clinical outcomes, decrease admissions, minimize readmissions, and address EC utilization for risk stratified patients in need of additional support. Therefore, we expect to achieve a TBD decrease in hospital admissions, a TBD decrease in readmissions, and a TBD decrease in EC utilization for the patients enrolled in the care management program.

**Rationale:**

We have only just begun to pilot the role of case manager in our Ambulatory Clinics. Many new providers and mid-levels are being hired into Ambulatory clinics in order to improve access. In order to address the barriers identified in the project description, and in order to be successful, stakeholder engagement including leaders and providers and other clinic personnel must be engaged for this model to be successful. A documented plan with timelines and accountability will assist to keep us on course due to day in day out distractions. We will know we are successful when clinic no show rates improve and when patients, assigned to a care team, visit the hospital less frequently for their primary care for conditions better managed in the community. Therefore, it was necessary to select process milestones P-1 and P-2. The improvement targets were chosen based on the need for alignment among all stakeholders and that documentation to validate and hardwire agreed upon process steps.

**Outcome Measure Valuation:**

Project valuation for an efficient and comprehensive Care Model was rated at the highest valuation level and is defined predominantly through cost avoidance. Assuming the patients are receiving, case management support, social services support, and medically appropriate patient education, the result should be a reduction of admissions and readmissions as well as a decrease in EC utilization. Patient and provider satisfaction will be improved with projected valuation, as well. This project achieves the Waiver goals by a) improving the health care infrastructure to better serve the Medicaid and uninsured residents of the county; b) further developing and maintaining a coordinated care delivery system; c) contributing to patients’ receiving high-quality, patient-centered care in the most cost-effective way; and serving as a powerful tool to help providers improve outcomes and reduce ED utilization (containing cost growth).
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Meeting minutes</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $0</td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: IDX/Truven Health/Crimson</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $248,110</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-2.13] Other Admission Rate (Stand-Alone Measure)</td>
</tr>
<tr>
<td>Target: TBD decrease in hospital admissions, TBD decrease in readmissions, TBD decrease in EC utilization for patients enrolled in the care management program.</td>
</tr>
<tr>
<td>a. Numerator: Admissions/Readmin to hospital/EC of patients for Care Team</td>
</tr>
<tr>
<td>b. Denominator: Active panel of patients for Care Team</td>
</tr>
<tr>
<td>c. Data Source: EMR/IDX/Crimson/Truven Health/Allscripts</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $399,542</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 [IT-2.13] Other Admission Rate (Stand-Alone Measure)</td>
</tr>
<tr>
<td>Target: TBD decrease in hospital admissions, TBD decrease in readmissions, TBD decrease in EC utilization for xxx patients enrolled in the care management program.</td>
</tr>
<tr>
<td>a. Numerator: Admissions/Readmin to hospital/EC of patients for Care Team</td>
</tr>
<tr>
<td>b. Denominator: Active panel of patients for Care Team</td>
</tr>
<tr>
<td>c. Data Source: EMR/IDX/Crimson/Truven Health/Allscripts</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $578,344</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,225,996**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization (Standalone measure)</th>
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<tbody>
<tr>
<td>Unique RHP ID#: 092414401.3.3</td>
</tr>
<tr>
<td>Provider name: Community Medicine Associates – PASS 2</td>
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<tr>
<td>TPI: 92414401</td>
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</tbody>
</table>

### Outcome Measure Description:

**IT-9.2 ED appropriate utilization (Standalone measure)**

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Chronic Obstructive Pulmonary Disease
  - Behavioral Health
  - Diabetes
  - Asthma

### Process Milestones:

Determining a process for gathering the data and developing baseline will be conducted in DY2 and DY3.

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-2 Establish baseline rates for reduction in ED visits for targeted conditions

### Outcome Improvement Target for each year:

- **DY4**: Improvement Target: Reduce ED visits for targeted conditions by X% from baseline Y3
- **DY5**: Improvement Target: Reduce ED visits for targeted conditions by X% from baseline Y3

### Rationale:

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. The targeted population will be the Carelink members assigned to University Health System patient centered medical homes. CareLink is a financial assistance program for uninsured residents of Bexar County. The program was created in 1997 to help address the needs of Bexar County residents without health care coverage who were not eligible for Medicaid or other public or private funding. While CareLink is not an insurance product per se, it has many similar advantages in terms of promoting access to preventive health services, encouraging a long lasting relationship with a primary care provider, and instilling a sense of shared responsibility between member and staff for the member’s health. As of December 31, 2011, there were 54,256 members enrolled in CareLink.
### Outcome Measure Valuation:

This outcome will be valued based on the number of emergency visits avoided by patients with COPD, behavioral health diagnoses, diabetes exacerbations, and asthma. The rationale is implementing the PCMH allows for expanded primary care, better care coordination, and improved chronic disease management. This supports a reduction in avoidable emergency center visit for patients with these specific conditions.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Establish baseline rates for reduction in ED visits for targeted conditions.</td>
<td>IT-9.2 ED appropriate utilization: Improvement Target: Reduce ED visits for targeted conditions by X% from baseline Y3. TBD</td>
<td>TBD</td>
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<tr>
<td>Data Source: Meeting minutes</td>
<td>Metric 1: Number of annual ER visits for CareLink patients with COPD, behavioral health, diabetes and asthma.</td>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $0</td>
<td>Metric 2: Number of avoidable ER visits for CareLink patients with these medical conditions.</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $399,542</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $578,343</td>
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<td></td>
<td>Data Source: Sunrise, IDX, volume reports, quality reports</td>
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<td></td>
<td>Process Milestone 2 Estimated Incentive Payment: $248,110</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
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<td>Year 3 Estimated Outcome Amount: $0</td>
<td>Year 4 Estimated Outcome Amount: $0</td>
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<td>Year 3 Estimated Outcome Amount: $248,110</td>
<td>Year 3 Estimated Outcome Amount: $248,110</td>
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<td>Year 5 Estimated Outcome Amount: $578,343</td>
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<td>Year 4 Estimated Outcome Amount: $399,542</td>
<td>Year 4 Estimated Outcome Amount: $399,542</td>
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<td>Year 5 Estimated Outcome Amount: $578,343</td>
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<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,225,995</td>
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</table>
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-4.10 Other Outcome Improvement Target: Enhance Improvement Capacity within People (Improving Inter-professional Team-Based Care for Patient Safety)
Unique RHP ID#: 085144601.3.1 – PASS 1
PERFORMING PROVIDER: University of Texas Health Science Center at San Antonio; Kathleen R. Stevens, RN, EdD, FAAN
TPI: 085144601

Outcome Measure Description:
DYs 2 and 3 Process Milestones

Process Milestone 1
P-1. Project Planning-Engage stakeholders, identify current capacity and document implementation plan.

Process Milestone 2
P-2. Establish baseline for team attitudes toward team-based performance.

Outcome Improvement Targets

YEAR 4:
OUTCOME MEASURE: AHRQ Teamwork Attitudes Questionnaire
1-X-1 METRIC Average of 5% gain of cohort on team performance (difference on Pre and Post scores on trainee-reported AHRQ Teamwork Attitudes Questionnaire)

OUTCOME MEASURE: AHRQ Medical Office or Hospital Survey on Patient Safety Culture
1-X-2 METRIC Average of 5% gain of cohort on culture of patient safety (difference on Pre and Post scores on trainee-reported AHRQ culture of patient safety survey)

YEAR 5:
OUTCOME MEASURE: AHRQ Teamwork Attitudes Questionnaire
1-X-1 METRIC Average of 5% gain of cohort on team performance (difference on Pre and Post scores on trainee-reported AHRQ Teamwork Attitudes Questionnaire)

OUTCOME MEASURE: AHRQ Medical Office or Hospital Survey on Patient Safety Culture
1-X-2 METRIC Average of 5% gain of cohort on culture of patient safety (difference on Pre and Post scores on trainee-reported AHRQ culture of patient safety survey)

Rationale:
Nationally referenced measures will be used to gather data on staff opinions about patient safety issues, medical error, and event reporting. Specifically, The AHRQ Survey on Patient Safety Culture (SOPS) (Sorra & Nieva, 2004; Sorra & Dyer, 2011) will be used to gather data on staff opinions about patient safety issues, medical error, and event reporting during Year 4 and 5. One of two versions of SOPS will be used, depending on the setting. Both measure 12 areas of composites of patient safety culture. The scales demonstrate high reliability (Sorra & Dyer, 2010). An advantage of the SOPS is the opportunity it provides for referencing local data to national benchmarks. AHRQ produces a national comparative database report that provides survey results on over 1,000 healthcare settings, classified by setting characteristics and respondent characteristics (e.g., work area and staff position). These national data will be used
as benchmarks to better evaluate the local results.

**Outcome Measure Valuation:**

<table>
<thead>
<tr>
<th>Outcome Measure Valuation:</th>
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<tbody>
<tr>
<td>Because a healthcare setting’s culture of patient safety is demonstrated to be directly related to prevention of healthcare associated harm and reflects higher organizational just cultures, teams that hold strong allegiance to high team performance are crucial within the context of the high reliability organization. The project valuation is based on creating a care climate that potentially prevents adverse medical events. The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<tbody>
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<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>P-1. Project Planning-Engage stakeholders, identify current capacity and document implementation plan.</td>
<td>P-2. Establish baseline for team attitudes toward team-based performance.</td>
<td>IT-4.10: Increase by 5% the scores on Culture of Patient Safety, pre- and post-training intervention (including QIO project completion)</td>
<td>IT-4.10: Increase by 5% the scores on Culture of Patient Safety, pre- and post-training intervention (including QIO project completion)</td>
</tr>
<tr>
<td>Data Source: Training program records and project planning document.</td>
<td>Data Source: Teamwork Attitudes Questionnaire (AHRQ) self-report of TeamSTEPPS participants.</td>
<td>Data Source: AHRQ Survey of Patient Safety Local Scores from newly trained TeamSTEPPS following their improvement project.</td>
<td>Data Source: AHRQ Survey of Patient Safety Local Scores from newly trained TeamSTEPPS following their improvement project.</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $21,411</td>
<td>Process Milestone 2 Estimated Incentive Payment: $49,636</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $53,098</td>
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<td>Year 3 Estimated Outcome Amount: $49,635</td>
<td>Year 4 Estimated Outcome Amount: $53,098</td>
<td>Year 5 Estimated Outcome Amount: $115,431</td>
</tr>
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</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $239,575
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in Identified disparity group
Unique RHP ID number: 085144601.3.2 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:
Outcome Measure: Improvement in Clinical Indicator in Identified disparity group
We will focus our project on improving outcomes of low income Latino patients with Medicaid, CareLink (county-funded financial assistance), and no insurance who are not meeting quality of care, health maintenance goals or requiring treatment with narcotics for pain. We will first target individuals with diabetes mellitus who have a mean hemoglobin (Hb) A1C level of \( \geq 7.5\% \) which increases the patients’ risk of diabetes complications. Second, we will identify a similar cohort of persons who have sustained uncontrolled systolic hypertension, which is the dominant form of uncontrolled hypertension. Third, we will identify persons who have chronic non-cancer pain and are treated with narcotics long-term since these individuals are known to be heavy users of emergency and hospital services as well as at risk for overdose events. Finally, we will identify HIV-infected persons in our local HIV clinic who have Ryan White or CareLink insurance because we have found that over 60% are overweight or obese and are still having significant weight gain.

Milestones

Year 2:
- P-1 Project Planning-engage stakeholders from study practices, administrators from involved health care systems and patients in those practices identify current capacity and needed resources.
- P-2 Establish baseline rates of uncontrolled hypertension, elevated hemoglobin A1c, and weight of HIV-infected persons who have Ryan White or CareLink insurance in our clinics as well as quality of care measures for patients on long-term opioids (>90 days in 180)

Year 3:
- P-3 Develop and test data derived from the registries
- P-4 Conduct plan do Study Acts (PDSA) cycles to improve data collection and intervention activities.

Year 4:
- P-5 Implement patient support programs, disseminate findings, including lessons learned and best practices, to stakeholders throughout the community

Year 5:
- Improvement in clinical indicators in identified disparity group vs. other patients

Outcome improvement targets:
Year 4:
(IT-11.1]: Improvement in clinical indicators in both Hispanic and non-Hispanic populations related to hypertension control, reduction in rapid risk in BMI of HIV infected patients who are overweight or obese, hemoglobin A1C. But reductions are expected to be greater in Hispanics group because of poorer status at baseline.

Year 5:
Rationale:

Related to Category 3 Outcome Measures, this project will address Outcome Dimension 11: Addressing Health Disparities in Minority Populations, specifically Improvement in Clinical Indicators in Latino Populations. The clinical indicators chosen for this project include hypertension control, HbA1c reduction, and HIV care goals of reducing excessive weight gain in persons who are overweight or obese. These measures are a priority for the RHP because research and national surveys conducted by the CDC have shown that low-income, Latino populations are disproportionately affected by poor clinical and functional status reflecting poor achievement of chronic disease management goals and a high prevalence of overweight and obesity. Thus, morbidity and chronic disease management are areas of great concern for providers caring for Latinos. Our population is over 60% Latino in our primary care clinics and, in our HIV clinic, Latinos and African-Americans represent 77% of our patient population. In terms of hypertension, the goal of this project is to improve the comprehensiveness of our data entry and its accuracy so that valid blood pressure data are recorded for at least 90% of our Latino population. For Latinos with a mean HbA1c over 7.5, efforts to reduce this level to under 7.5 is not only cost-effective but and reduces the risk of diabetes complications when <7% according to the ADA. We propose to reduce the mean HbA1c from the current 7.7% in our study practices to 7.3 (5% absolute reduction) by targeting the persons who fail to keep their appointments and who have elevated HbA1c. We will also use our visit arrival status variable to target persons who need additional support. We have found that the average relative reduction in HbA1c for persons with an HbA1c over 8% at baseline is -15.9% for persons who keep >75% of visits vs. only -9.5% for persons who keep <60% of visits. We will also target minority patients in our HIV clinic to raise consciousness about the risks of obesity and offer specific, culturally appropriate support programs to help control weight gain – both in the practice and in the community (e.g. Weight Watchers). Similarly, we will reduce the proportion of Latinos who have uncontrolled hypertension despite therapy by 10% and achieve at least a 3-5 mmHg reduction in systolic blood pressure. We will be able to achieve these goals by using the registry to define patients who need additional support to achieve goals and to implement evidence-based community health worker (promotora) interventions to address these health risks through promotoras and peer support. In collaboration with the patient practices, promotoras and trained peers will provide culturally appropriate outreach aimed at reducing disparities for low-income and Latinos. The use of promotora and peers support is particularly effective in minority populations and has been shown to significantly reduce HbA1c, systolic blood pressure, and improve receipt of needed cancer prevention services. For example, to reduce significant disparities in cardiovascular risk, Dr. Turner led a successful randomized controlled trial of peer support for uncontrolled hypertension in an African-American population that resulted in a reduction in systolic blood pressure that was equal to adding a new drug (Turner BJ et al. JGIM 2012). As in prior research conducted by Dr. Turner, we will train a community based providers, promotoras, and peers to support patients to achieve their disease goals. These are evidence-based interventions that offer culturally appropriate outreach aimed at reducing disparities for low-income. Latino patients.

The process milestones were chosen as stated above in order to develop a strong collaborative
team approach between the clinical staff, administrators, stakeholders, and participating practices. The first steps in DY 2 will be project planning (P-1) through stakeholders who include community advisory board members, providers from study practices, and Latino patients to review barriers to achieving reductions in baseline poor control of (P-2) of HbA1C, systolic blood pressure and excessive increase in BMI in HIV-infected persons. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baseline status on key clinical variables from which to measure the success of the promotora and peer coach support intervention. In particular, we chose to add Process milestone P-3 --Develop and test data systems -- in order to determine any new systemic changes necessary to obtain needed data that were not available in DY2 especially targeting factors that are important to Latinos. We chose to add (P-5) to disseminate findings, including lessons learned and best practices, to stakeholders in DY 4 and DY 5 to improve the understanding and use of the registry. To accomplish this we will partner with the federally funded Area Health Education Center (AHEC) that has a strong relationship with healthcare providers throughout our region as well as key community stakeholders from major organizations and businesses.

Outcome Measure Valuation:

Achieves Waiver Goals: This project will work to reduce well observed disparities that patients from under-represented minorities -- especially those on Medicaid, receiving financial assistance for care, or uninsured -- have in receiving high quality, patient-centered care that will improve chronic disease care status as well as ultimately reduce unnecessary complications that increase hospital and emergency room utilization. Previous research on the effectiveness of patient registries shows that they facilitate identification of at-risk patients and, for diabetics, can direct programs to help patients meet Hgb A1c control goals and reduce complications as well as costs of care. Dr Turner’s previous research has used registries to examine racial disparities in hypertension control and management of hyperlipidemia (Umscheid, Gross, Weiner, Hollenbeak, Tang, Turner, 2010; Turner, Hollenbeak, Weiner, Ten & Roberts, 2009; Turner, Hollenbeak, Weiner & Tang, 2011)

Address Community Need(s): This project addresses community priority needs described in the Community Health Improvement Plan for Bexar County for: Healthy Eating and Active Living and Behavioral and Mental Well-Being. Priority health issues addressed by this project include diabetes, obesity, and hypertension. Registries are increasingly adopted nationally to effectively characterize patient health care needs and respond with appropriate interventions. Through the diabetes and other registries, we will make this unique resource available to providers and patients in order to guide efforts to achieve the goals of the Community Health Improvement Plan for Bexar County.

Project Scope: All the proposed database registries will include approximately 10,000 patients and 30 providers. Providers who are recruited and trained in using these data will be more empowered to improve patient outcomes by targeting interventions and support to those who need it most. The cost of diabetes is high (as of 2007, $91.8 billion in direct costs and $39.8 billion spent on indirect expenses) and rising. Previous research estimates costs will be decreased if we are able to decrease hemoglobin A1c (a $2,536 cost differential accrued over 3 years between patients with an A1c of 6% to 7% versus those 9% to 10% who had diabetes along with comorbid heart disease and hypertension) (Gilmer TP, O'Connor PJ, Rush WA, et al. Predictors of health care costs in adults with diabetes. Diabetes Care.2005;28:59–64). Similar to diabetes, obesity and hypertension also incur increased costs of care relative to persons without these
conditions. However one of the critical aspects of both diabetes and obesity are of the fact that it disproportionately affects minorities. In our Texas region obesity is a major health risk for Latinos and it even affects HIV-infected Latinos. Our goal in this project is to start to address some of these health disparities that put Latinos increased risk of diabetes complications as well as other ravages of obesity in regard to the degenerative joint disease and chronic pain. The proposed registry will allow us to see a decrease in the clinical indicators of hypertension control, stabilization of BMI of HIV infected patients who are overweight or obese, hemoglobin A1C among Hispanics in the registry.

**Project Investment:** The expected investment in this program for Human Resources will include the cost of promotoras, project coordinator, peer coaches and the data mining team. Equipment purchase and maintenance will be covered by our accompanying project to develop a Health Information Exchange and improved data linkages between the data derived from the Sunrise electronic medical record and UT medicine billing data – making this a relatively cost-effective project. The time to implementation of updated diabetes and HIV registries will be one year which will be used to complete the registry and hire and train staff in use of the registry. Subsequent hypertension registry will be completed in year 2-3 and staff trained by year 4. We will also develop the database of patients on long-term opioids by the end of year 3. Several organizational priorities will be met by the development of these longitudinal chronic disease registries but the most important is to insure that we provide comprehensive, value-based care that improves the health of the vulnerable populations that we serve.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 3</th>
<th>Process Milestone 4</th>
<th>Process Milestone 5</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1] Project Planning- to engage stakeholders who will examine current capacity and needed resources. <strong>Data Sources:</strong> Meetings with the directors of all the primary care practices, selected patients—especially Latinos, and representatives of the community to review the role of the promotor/peer support and any current initiatives that might be duplicative. <strong>Metric:</strong> Documentation of stakeholders/directors that attend meetings.</td>
<td>[P-3] Develop and test data <strong>Data Source:</strong> Registry identification of defined ‘at-risk’ patients who are Latinos linked to participating primary care practices. <strong>Metric:</strong> Documentation of at-risk, Latino patients who have not achieved their chronic disease management goals and who do not keep at least 75% of their scheduled clinic visits that will be linked to primary care practices.</td>
<td>[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Hire/train promotoras, identify disease appropriate peer coaches from practices who are from a similar demographic group (Latinos but who have achieved the health care goals to serve as role models</td>
<td>[P-5] Disseminate findings, including lessons learned and best practices, to stakeholders with the assistance of the AHEC that has strong linkages with diverse constituencies throughout our larger San Antonio and South Texas Region. <strong>Data Source:</strong> Pilot data from PDSA disseminated to primary care practices in the study and affiliated clinics (UT Medicine, University Health System as well as partners at University Health System). <strong>Metric:</strong> Report status, progress and lessons learned to stakeholders from our local community as well as Statewide through meetings, website information, and publications—these lessons will be useful for clinics that manage similar large numbers of low income Latinos with diabetes, hypertension, and chronic pain on long-term opioids.</td>
<td></td>
</tr>
<tr>
<td>[P-2] Establish baseline rates <strong>Data Source:</strong> Registry data for diabetes, hypertension, long-</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment: $24,087</strong></td>
<td><strong>Process Milestone 4 Estimated Incentive Payment: $55,839.50</strong></td>
<td><strong>Process Milestone 5 Estimated Incentive Payment: $24,087</strong></td>
<td><strong>Process Milestone 5 Estimated Incentive Payment: $24,087</strong></td>
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<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
<td>Year 5</td>
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**Outcome Improvement Target 2**

**[IT-11.1]: Improvement in Clinical Indicators in identified disparity group – year 2**

**Data Source:** Registry – documenting changes in study metrics for population served over one year through the DSRIP initiative Provider interviews – documenting their feedback about the program to patients Patient interviews – documenting their response to the support intervention

**Numerator:** Number of Latino patients with improved clinical indicators and measurement of patient satisfaction with interventions in the second year of the intervention

**Denominator:** Total number of Latino patients in registry with specific conditions who
<table>
<thead>
<tr>
<th>Process Milestone</th>
<th>Estimated Incentive Payment</th>
<th>Outcome Improvement Target 1</th>
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<tbody>
<tr>
<td>1</td>
<td>$24,087</td>
<td>Improvement in Clinical Indicators in identified disparity group</td>
</tr>
<tr>
<td>2</td>
<td>$55,839.50</td>
<td><strong>Outcome Improvement Target 1</strong>[IT-11.1]: Improvement in Clinical Indicators in identified disparity group</td>
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<tr>
<td>3</td>
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<td>Data Source: Registry – documenting changes in study metrics for population served over one year through the DSRIP initiative</td>
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<tr>
<td>4</td>
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<td>Goal: TBD</td>
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<td></td>
<td></td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment</strong>: $259,719</td>
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</table>

**Term opioids, and HIV populations**

**Metric**: Establishment of baseline rates of HbA1C, systolic blood pressure, BMI of HIV-infected persons, and use of opioid use agreements, urine drug screens, and regular 3-6 monthly visits for patients on long-term opioids.

Process Milestone 2 Estimated Incentive Payment: $24,087

**Outcome Improvement Target 1**

Data Source: Documentation of the quality of data in the registry
Development and evaluation of a pilot intervention targeting at-risk persons in the 3 disease groups (hypertension, diabetes, HIV) with a review to address challenges.

**Metric**: Establishment of training programs developed/conducted and list of promotoras and peers hired and trained – we will focus on ensuring that we have adequate numbers of Latinos who are trained in these roles to help address health disparities

Process Milestone 4 Estimated Incentive Payment: $55,839.50

**Goal**: TBD

**Outcome Improvement Target 2 Estimated Incentive Payment**: $259,719

**Data Source**: Registry – documenting changes in study metrics for population served over one year through the DSRIP initiative

**Provider interviews** – documenting their feedback about the program to patients

**Patient interviews** – documenting their satisfaction to the support intervention

**Numerator**: Number of patients with improved clinical indicators who are Latino

**Denominator**: Total number of Latino patients in registry with specific clinical conditions

Baseline: Currently, the 2026 patients with diabetes in the registries for the 2 Brady Green sites have a mean HbA1c of 7.7 (SD1.9), compared with a baseline mean of 8.1 (SD 2.1). We also will focus on hypertension as an outcome. Currently 34% of these patients with diabetes have a mean
systolic blood pressure over 140 mmHg and 60% have a mean over 130 (ideal is <130). In our prior interventions, we have been able to reduce systolic blood pressure by 6 mmHg with a peer intervention. For the HIV infected patients who are overweight or obese, 60% of the population, we will work to reverse the observed rapid weight gain to <1% BMI per year.
Goal: TBD for DY 4 and 5
Outcome Improvement Target 1
Estimated Incentive Payment: $119,471

| Year 2 Estimated Outcome Amount: $48,174 | Year 3 Estimated Outcome Amount: $111,679 | Year 4 Estimated Outcome Amount: $119,471 | Year 5 Estimated Outcome Amount: $259,719 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $539,043**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap
Unique RHP ID number: 085144601.3.3 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:

Outcome Measure: Improvement in disparate health outcomes for target population, including identification of the disparity gap

We will focus our project on improving outcomes of low income Latino patients with Medicaid, CareLink (county-funded financial assistance), and no insurance relative to non-Hispanic whites who have a similar insurance groups. We will first target individuals with diabetes mellitus who have a mean hemoglobin (Hb) A1C level of \( \geq 7.5\% \) which increases the patients’ risk of diabetes complications. Second, we will identify a similar cohort of persons who have sustained uncontrolled systolic hypertension, which is the dominant form of uncontrolled hypertension. Third, we will identify persons who have chronic non-cancer pain and are treated with narcotics long-term since these individuals are known to be heavy users of emergency and hospital services as well as at risk for overdose events. Finally, we will identify HIV-infected persons in our local HIV clinic who have Ryan White or CareLink insurance because we have found that over 60% are overweight or obese and are still having significant weight gain.

Milestones

Year 2:
- P-1 Project Planning-engage stakeholders identify current capacity and needed resources.
- P-2 Establish baseline rates of uncontrolled hypertension, elevated hemoglobin A1c, and BMI in HIV-infected persons who have Ryan White or CareLink insurance in our clinics

Year 3:
- P-3 Develop and test data
- P-4 Conduct plan do Study Acts (PDSA) cycles to improve data collection and intervention activities.

Year 4:
- P-5 Implement patient support programs Disseminate findings, including lessons learned and best practices, to stakeholders

Year 5:
- Improvement in clinical indicators in identified disparity group vs. other patients

Outcome improvement targets:

Year 4:
[IT-11.2]: Improvement in disparate health outcomes for target population, including identification of disparity gap

Year 5:
[IT-11.2]: Improvement in disparate health outcomes for target population, including identification of disparity gap
Rationale:
Related to Category 3 Outcome Measures, this project will address Outcome Dimension 11: Addressing Health Disparities in Minority Populations, specifically Improvement in Clinical Indicators in Latino Populations. The clinical indicators chosen for this project include hypertension control, Hb A1C reduction to goal, and HIV care goals of reducing excessive weight gain in persons who are overweight or obese. These measures are a priority for the RHP because research and national surveys conducted by the CDC have shown that low-income, Latino populations are disproportionately affected by poor clinical and functional status reflecting poor achievement of chronic disease management goals and a high prevalence of overweight and obesity. This project will focus on reducing gaps between Latinos and non-Hispanic whites. For persons with a mean HbA1c over 7.5, efforts to reduce this level to under 7.5 is not only cost-effective but and reduces the risk of diabetes complications when <7% according to the ADA. For example we know that in our two primary care clinics, 55.7% of Latinos (81.7% of all diabetic patients in these practices) have a HbA1c under 7.5 versus 61.2% of whites (11% of diabetics in practices). Although our African-American diabetic population is much smaller (7.1%), they will also benefit from this intervention because in that group the proportion with an HbA1c under 7.5 is only 50.4%. We propose to reduce the mean HbA1c from the current 7.7% in our study practices to 7.3 (5% absolute reduction) by targeting especially the Latinos persons who fail to keep their appointments and who have elevated HbA1c. Currently, we have found that the average relative reduction in HbA1c for persons with an HbA1c over 8% at baseline is -15.9% for persons who keep >75% of visits vs. only -9.5% for persons who keep <60% of visits. Thus, these patients are less likely to benefit from longitudinal diabetes care.

Similarly, we will reduce the proportion of patients who have uncontrolled hypertension despite therapy by 10% and achieve at least a 3-5 mmHg reduction in systolic blood pressure. In regard to obesity in the HIV clinic, the most rapid weight gain among the persons who are overweight or obese is observed in the minority patients who have either CareLink or Ryan White insurance. We will be able to achieve these goals by using the registry to define patients who need additional support to achieve goals and to implement evidence-based community health worker (promotora) interventions to address these health risks through promotoras and peer support. In collaboration with the patient practices, promotoras and trained peers will provide culturally appropriate outreach aimed at reducing disparities for low-income, Latino patients. To address health disparities, Dr. Turner led a successful randomized controlled trial of peer support for uncontrolled hypertension in a minority population that resulted in a reduction in systolic blood pressure similar to adding a new drug (Turner BJ et al. JGIM 2012). As in prior research conducted by Dr. Turner, we will train non physician, community based providers and peers to support patients to achieve their disease goals. These are evidence-based interventions that offer culturally appropriate outreach aimed at reducing disparities for low-income and Hispanic patients.

In the past decade, diagnosis, management, and control of hypertension (HTN) has improved significantly but several groups continue to lag behind including: persons with diabetes mellitus (DM), non-Hispanic blacks, and Mexican-Americans (Gu, Burt, Dillon & Yoon, 2012). Similarly to hypertension, Hispanics are more likely than the general population to develop diabetes. It is estimated that 2.5 million, or 10.4 percent of Hispanic and Latino Americans aged 20 and older have diabetes. Hispanics also are more likely to have undiagnosed diabetes than non-Hispanic whites and non-Hispanic blacks (National Alliance of Hispanic Health, 2010). Unfortunately, minority groups disproportionately bear this dual disease burden. We will also be measuring and addressing the BMI of HIV-infected persons who are primarily comprised of
Hispanics and blacks locally and nationally (Hall HI, Song R, Rhodes P, et al., 2008). Weight gain has been identified as a problem for HIV-infected patients (Torriani, Fitch, Stavrou, et al., 2012) and this registry will allow us to target patients who require additional support to reduce rapid weight gain.

The process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stakeholders, and participating practices. The first steps in DY 2 will be project planning (P-1) through the use of a community advisory board members who will be referred to as stakeholders, then establishment of baseline rates (P-2) of HbA1C, diastolic blood pressure and BMI of HIV-infected persons. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the promotora intervention. In particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2. We chose to add (P-5) Disseminate findings, including lessons learned and best practices, to stakeholders in DY 4 and DY 5 to improve on the understanding and use of the registry.

**Outcome Measure Valuation:**

**Achieves Waiver Goals:** This project assures that patients -- especially those on Medicaid or uninsured --will receive high quality, patient-centered care with high value services that will reduce use of costly urgent care services and reduce unnecessary or duplicative tests/services. Previous research on the effectiveness of patient registries show that they facilitate identification of at-risk patients and, for diabetics, can direct programs to help patients met Hgb A1c control goals and reduce complications as well as costs of care.

**Address Community Need(s):** This project addresses community priority needs described in the Community Health Improvement Plan for Bexar County for: Healthy Eating and Active Living and Behavioral and Mental Well-Being. Priority health issues addressed by this project include diabetes, obesity and hypertension. Registries are increasingly adopted nationally to effectively characterize patient health care needs and respond with appropriate interventions. Through the diabetes and other registries, we will make this unique resource available to providers and patients in order to guide efforts to achieve the goals of the Community Health Improvement Plan for Bexar County.

**Project Scope:** The proposed database registries will include approximately 10,000 patients with 30 providers (faculty, residents, and medical students). Providers who are recruited and trained in using these data will be more empowered to improve patient outcomes by targeting interventions and support to those who need it most – especially Latinos. The cost of diabetes is high (as of 2007, $91.8 billion in direct costs and $39.8 billion spent on indirect expenses) and rising. Previous research estimates costs will be decreased if we are able to decrease hemoglobin A1c (a $2,536 cost differential accrued over 3 years between patients with an A1c of 6% to 7% versus those 9% to 10% who had diabetes along with comorbid heart disease and hypertension) (Gilmer TP, O'Connor PJ, Rush WA, et al., 2005). Similarly to diabetes, obesity and hypertension also have high costs. This proposed registry will allow us to identify the gap that exists between Hispanics and non-Hispanics in regard to specified clinical indicators. We will conduct multivariable analyses examining the association of race-ethnicity with improvement in clinical
indicators – systolic blood pressure, HbA1c, and BMI (in HIV-infected persons).

**Project Investment:** The expected investment in this program for Human Resources will include the cost of trainers, promotoras, project coordinator and the data mining team. Equipment purchase and maintenance will be covered by our accompanying project to develop a Health Information Exchange – making this a relatively cost-effective project. The time to implementation of updated diabetes and HIV registries will be one year which will be used to complete the registry and hire and train staff in use of the registry. Subsequent hypertension registry will be completed in year 2-3 and staff trained by year 4. Several organizational priorities will be met by the development of these longitudinal chronic disease registries but the most important is to insure that we provide comprehensive, value-based care that improves the health of the vulnerable populations that we serve.
### Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Addressing Health Disparities in Minority Populations)

<table>
<thead>
<tr>
<th>085144601.3.3 PASS 1</th>
<th>3.IT-11.2</th>
<th>University of Texas Health Science Center at San Antonio</th>
<th>TPI - 085144601</th>
</tr>
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<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
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<tr>
<td>Starting Point/Baseline:</td>
<td></td>
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<td>TBD in DY 2</td>
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</tbody>
</table>

<p>| Year 2 (10/1/2012 – 9/30/2013) | Process Milestone 1 [P-1] | Project Planning - engage stakeholders identify current capacity and needed resources. <strong>Data Sources:</strong> Meetings with directors of the two primary care practices to review the role of the promotora/peer support and any current initiatives that might be duplicative. <strong>Metric:</strong> Documentation of stakeholders/directors that attend meetings. | <strong>Process Milestone 1 Estimated Incentive Payment:</strong> $24,087 |
| Year 3 (10/1/2013 – 9/30/2014) | Process Milestone 2 [P-2] | Establish baseline rates. <strong>Data Source:</strong> Registry data for diabetes, hypertension and HIV populations. <strong>Metric:</strong> Establishment of baseline rates of HbA1c. | <strong>Process Milestone 2 Estimated Incentive Payment:</strong> $24,087 |
| Year 4 (10/1/2014 – 9/30/2015) | Process Milestone 3 [P-3] | Develop and test data collection and intervention activities. <strong>Data Source:</strong> Registry identification of defined ‘at-risk’ patients – regardless of race-ethnicity - linked to participating primary care practices. <strong>Metric:</strong> Documentation of at-risk patients linked to primary care practices. | <strong>Process Milestone 3 Estimated Incentive Payment:</strong> $55,839.50 |
| Year 5 (10/1/2015 – 9/30/2016) | Process Milestone 4 [P-4] | Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Hire/train promoters and disease appropriate peers. <strong>Data Source:</strong> Documentation of the quality of data in the registry Development and | <strong>Process Milestone 4 Estimated Incentive Payment:</strong> $0 |
| | Process Milestone 5 [P-5] | Disseminate findings, including lessons learned and best practices, to stakeholders. <strong>Data Source:</strong> Pilot data from PDSA disseminated to primary care practices in the study and affiliated clinics (UT Medicine, as well as partners at University Health System) <strong>Metric:</strong> Report status, progress and lessons learned to stakeholders. | <strong>Process Milestone 5 Estimated Incentive Payment:</strong> $0 |
| | Outcome Improvement Target 1 | [IT-11.2]: Improvement in disparate health outcomes for target population, including identification of disparity gap – year 1 intervention. <strong>Data Source:</strong> Registry data. | <strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $0 |
| | | <strong>Outcome Improvement Target 2</strong> | <strong>Outcome Improvement Target 2</strong> |
| | | [IT-11.2]: Improvement in disparate health outcomes for target population, including identification of disparity gap – year 2 intervention, sustained effects. <strong>Data Source:</strong> Registry data obtained to evaluate the promotora/peer support program – examining pre vs. post values in key metrics including Hgb A1c, blood pressure, and BMI in HIV-infected persons for Hispanics and non-Hispanics. <strong>Numerator:</strong> Number of patients with improved outcomes with specific insurances. <strong>Denominator:</strong> Total number of patients in registry with specific insurances. - We will conduct multivariable analyses adjusting for demographics, | <strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $0 |</p>
<table>
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<tr>
<th><strong>systolic blood pressure and BMI in HIV-infected persons.</strong></th>
<th><strong>evaluation of a pilot intervention targeting at-risk persons in the 3 disease groups (hypertension, diabetes, HIV) with a review to address challenges. Metric:</strong> Establishment of training programs developed/conducted and list of promotoras and peers hired and trained</th>
<th><strong>obtained to evaluate the promotora/peer support program – examining pre vs. post values in key metrics including Hgb A1c, blood pressure, and BMI in HIV-infected persons for Hispanics and non-Hispanics</strong> <strong>Numerator:</strong> Number of patients with improved outcomes with specific insurances <strong>Denominator:</strong> Total number of patients in registry with specific insurances - We will conduct multivariable analyses adjusting for demographics, clinical factors, and health care utilization examining the association of the intervention on reducing disparities by race-ethnicity in clinical indicators – systolic blood pressure, HbA1c, and BMI (in HIV-infected persons)</th>
<th><strong>clinical factors, and health care utilization examining the association of the intervention on reducing disparities by race-ethnicity in clinical indicators – systolic blood pressure, HbA1c, and BMI (in HIV-infected persons)</strong> <strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $119,471</th>
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<tr>
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<td>Year 4 Estimated Outcome Amount: $119,471</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $539,043**
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<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
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<tr>
<td><strong>Title of Outcome Measure (Improvement Target):</strong> IT-9.2 ED Appropriate Utilization</td>
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<tr>
<td><strong>Unique RHP ID:</strong> 085144601.3.4 – PASS 1</td>
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<td><strong>Performing Provider:</strong> University of Texas Health Science Center at San Antonio</td>
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<tr>
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<tr>
<td>IT-9.2 Right care in right setting-Reduce ED visits. Increase number of residents who remain in South Texas to practice after 2 years by 10%. 15% increase of primary care visits in the FHC during years 4 and 5</td>
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<tr>
<td>DY2</td>
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<tr>
<td>P-1 Develop a plan for the residency expansion</td>
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<td>DY3</td>
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<tr>
<td>P-2 Develop baseline for residency expansion</td>
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<td>DY4</td>
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<tr>
<td>IT-9.2 Decrease the number of emergency room visits per 100,000 individuals in San Antonio and South Texas</td>
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<tr>
<td>DY5</td>
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<tr>
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<th><strong>Rationale:</strong></th>
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<tr>
<td>We need work to develop strategies that encourage graduates of all of these programs to remain and practice in South Texas. This will each program to learn from each challenges and successes of other programs and disciplines. Texas has a serious shortage of primary care providers. Working together should allow us to develop ideas to select trainees that are likely to stay in Texas and to encourage them to stay after training.</td>
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<tr>
<td>Other projects within the overall proposal are designed to increase the primary care workforce. There is a natural collaboration with all venues for increasing primary care training, but most specifically with those that increase Family Physician training. This will fit very well with the project to start a new Family Medicine residency in the McAllen area. We will also be in a position two develop some interdisciplinary training with programs in the area that training Physician assistants and Family Nurse Practitioners.</td>
</tr>
<tr>
<td>Additionally, we work to develop strategies that encourage graduates of all of these programs to remain and practice in South Texas. This will each program to learn from each challenges and successes of other programs and disciplines. Texas has a serious shortage of primary care providers. Working together should allow us to develop ideas to select trainees that are likely to stay in Texas and to encourage them to stay after training.</td>
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<tr>
<td>There are also organizations and training programs training primary care providers that are not part of the DSRIP process (ex. other Family Medicine residency programs in Texas). We will plan to work with them closely on common issues. The Texas Academy of Family Physicians should be able to assist in developing forums to work on common problems with these</td>
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Measurement and tracking of changes will be done through the Annual Review of program effectiveness process. These results are reported to the department chair. The Associate Dean for Graduate Medical Education also receives the results of this process and has additional oversight for the educational processes.

There are multiple academic meetings at which the results can be disseminated. The most important would probably be the Texas Family Medicine Leadership Conference, which is sponsored by the Texas Academy of Family Physicians on a yearly basis. Most family medicine residencies in Texas have representatives at the meeting.

**Outcome Measure Valuation:**

Implementation of the Patient Centered Medical Home will require more primary care providers. Family Medicine is that specialty that trains the most physicians who remain in primary care for an extended part of their career. The number of physicians in practice is driven almost solely by the number of residency slots and is relatively unrelated to medical school training positions.

Size of expansion is based on a realistic assessment of the potential for additional quality training in this medical center. A much greater expansion is needed based on the future needs of the growing population of South Texas, but any expanded training must be high quality training.

Additional, patient care will occur in the Family Health Center as part of the residency expansion, but the greater impact will be in the additional primary care physicians practicing in South Texas.
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<td>TBD IN DY 3</td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 3</strong></td>
<td><strong>Outcome Improvement 1</strong></td>
<td><strong>Outcome Improvement 2</strong></td>
</tr>
<tr>
<td>Data Source: The generated plan</td>
<td>Data Source: TBD</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment:</td>
<td>Process Milestone 2 Estimated Incentive Payment:</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment:</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment:</td>
</tr>
<tr>
<td>$80,290</td>
<td>$186,132</td>
<td>$199,118</td>
<td>$432,865</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $80,290</td>
<td>Year 3 Estimated Outcome Amount: $186,132</td>
<td>Year 4 Estimated Outcome Amount: $199,118</td>
<td>Year 5 Estimated Outcome Amount: $432,865</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $898,405**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores, item - patient’s rating of doctor access to specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP Outcome Identification Number: 085144601.3.5 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider Name: University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Performing Provider TPI: 085144601</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

| In DY 2 the focus will be on project planning, establishing baseline patient satisfaction scores and developing and testing the EpicCareLink referral system. Once baseline satisfaction scores are available the outcome improvement target for DY 3-5 will be determined. DY 3 will be devoted to conducting Plan Do Study Act (PDSA) cycles, disseminating findings through learning collaboratives and beginning to demonstrate improvement in patient satisfaction scores. The focus in DY 4-5 will be continued improvement in patient satisfaction scores. |

### Rationale:

The RHP 6 needs assessment identified access to specialty care as a key health challenge for the region, and continued population growth is expected to exacerbate this problem in the future. A large academic medical center in the Midwestern US addressed a problem with specialty care access by implementing a web-based referral system, showing that referrals generated through that system were more than twice as likely to lead to a scheduled visit with a specialty physician (Weiner, M, El Hoyek, G. A web-based generalist-specialist system to improve scheduling of outpatient specialty consultations in an academic center. J Gen Intern Med. 2009 Jun;24(6):710-5). We expect that implementation of a similar web-based referral system (EpicCareLink) at UT Medicine will result in similar outcomes along with an improvement in patient satisfaction related to specialty referrals.

The process milestones of project planning, developing and testing the EpicCareLink referral portal, and establishing baseline patient satisfaction scores in DY 2 set the foundation for technical and operational success of the project. In DY 3 PDSA cycles and dissemination of findings to others and gaining knowledge from other groups through learning collaboratives will lead to further refinements in the technical configuration of the EpicCareLink referral portal and inform decisions on how to most effectively operationalize this technology to improve access to specialty care. We expect to see improvements in the outcome improvement target beginning in DY 3 through DY 5 and beyond.

### Outcome Measure Valuation:

The project valuation section state the project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
<table>
<thead>
<tr>
<th>085144601.3.5 PASS 1</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores - patient’s rating of doctor access to specialist.</th>
</tr>
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<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined – see process Milestone 2</td>
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</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;[P-1]: Project Planning – engage stakeholders, identify needed resources, document implementation plans&lt;br&gt;Data Source: Project team meeting minutes</td>
<td><strong>Process Milestone 4</strong>&lt;br&gt;[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.&lt;br&gt;Data Source: Project team minutes</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;[IT-6.1]: Percent improvement over baseline of patient satisfaction scores (3) patient’s rating of doctor access to specialist.&lt;br&gt; Improvement Target 1: to be determined during DY 2 based on baseline data.&lt;br&gt;Data Source: CG-CAHPS survey</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong>&lt;br&gt;[P-2]: Establish baseline patient satisfaction scores - patient’s rating of doctor access to specialist&lt;br&gt;Data Source: CG-CAHPS survey</td>
<td><strong>Process Milestone 5</strong>&lt;br&gt;[P-5]: Disseminate findings&lt;br&gt;Data Source: Learning Collaborative Presentations</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $14,274</td>
<td>Process Milestone 5 Estimated Incentive Payment: $33,090</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong>&lt;br&gt;[P-3]: Develop and test EpicCareLink referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $14,274</td>
<td>satisfaction scores (3) patient’s rating of doctor access to specialist. Improvement Target 1: to be determined during DY 2 based on baseline data. Data Source: CG-CAHPS survey</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $33,090</td>
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<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $42,821</td>
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<td></td>
<td>Year 5 Estimated Outcome Amount: $230,861</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $479,148**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%) NQF 0059 |
| Unique RHP Outcome Identification Number: 085144601.3.6 – PASS 1 |
| Performing Provider Name: University of Texas Health Science Center at San Antonio |
| Performing Provider TPI: 085144601 |

**Outcome Measure Description:**

| DY 2 will be devoted to project planning, developing and testing the chronic disease database/registry and establishing baseline rates of diabetic patients in the registry with HbA1C > 9.0%. In DY 3 we will begin to conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities, disseminate our findings to other groups and reduce the percentage of diabetic patients with HbA1C > 9.0% by 1% compared to the baseline that will be determined in DY 2. In DY 4 we will reduce the percentage of diabetic patients with HbA1C > 9.0% by another 1%. In DY 5 we will reduce the percentage of diabetic patients with HbA1C > 9.0% by another 1%, resulting in a reduction of 3% by the end of the waiver. |

**Rationale:**

| We have chosen IT 1.10 Diabetes care: HbA1c poor control (>9.0%) NQF 0059 (Standalone measure) as the Category 3 outcome measure for this project. Diabetes registries have been shown to be an effective tool to help manage underserved populations with diabetes as evidenced by improvements in A1C values (Seto W, Turner BS, Champagne MT, Liu L. Utilizing a diabetic registry to manage diabetes in a low-income Asian American population. Population Health Management 2012;15:220-229). Sixty percent of the 16,000 deaths in RHP 6 in 2008 were the result of preventable causes including diabetes. According to the RHP 6 Needs Assessment, “Disease management …programs are critical to reducing morbidity and mortality of these diseases.” |

| The process milestones of project planning, developing and testing the HIE and chronic disease registry, and establishing baseline rates of diabetic patients in the registry with HbA1C > 9% in DY 2 set the foundation for technical and operational success of the project. In DY 3 PDSA cycles and dissemination of findings to others and gaining knowledge from other groups through learning collaboratives will lead to further refinements in the HIE and chronic disease registry and inform decisions on how to most effectively operationalize this technology to improve the health of our underserved population. We expect to see improvements in the outcome improvement target beginning in DY 3 through DY 5 and beyond. |

**Outcome Measure Valuation:**

| In 2010 alone Bexar county had 14,769 potentially preventable hospitalizations costing approximately $372,000,000 at $25,212 per hospitalization (www.dshs.state.tx.us/ph). Improved chronic disease management will reduce the number of potentially preventable hospitalizations as well as preventable emergency department visits. We conservatively anticipate that this project will prevent at least 500 hospitalizations over the four year project period resulting in a total savings of $12,606,000. The project valuation section state the project is valued based upon achieving waiver goals, meeting community needs, scope, and investment. |
| **085144601.3.6**  
**PASS 1** | **3.IT-1.10** | **Diabetes care: HbA1c poor control (>9.0%)** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>085144601.1.5</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>26% of diabetics with an A1C &gt;9.0%</td>
<td></td>
</tr>
</tbody>
</table>

| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
|---|---|---|---|
| **Process Milestone 1**  
[P-1]: Project Planning – engage stakeholders, identify needed resources, document implementation plans  
Data Source: Chronic Disease Management Registry Committee (CDMRC) meeting minutes | **Process Milestone 4**  
[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  
Data Source: CDMRC minutes | **Outcome Improvement Target 2**  
[IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)  
NQF 0059  
Improvement Target: 1% improvement over baseline in this measure.  
Data Source: HIE database | **Outcome Improvement Target 3**  
[IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)  
NQF 0059  
Improvement Target: 1% improvement over baseline in this measure.  
Data Source: HIE database |
| Process Milestone 1 Estimated Incentive Payment: $35,684 | Process Milestone 4 Estimated Incentive Payment: $82,725 | Outcome Improvement Target 2 Estimated Incentive Payment: $265,491 | Outcome Improvement Target 3 Estimated Incentive Payment: $577,154 |
| **Process Milestone 2**  
[P-3]: Develop and test data  
Data Source: Chronic Disease Management Registry – which will be populated by the HIE | **Process Milestone 5**  
[P-5]: Disseminate findings  
Data Source: CDMRC meeting minutes |  |  |
| Process Milestone 2 Estimated Incentive Payment: $35,684 | Process Milestone 5 Estimated Incentive Payment: $82,725 |  |  |
| **Process Milestone 3**  
[P-2]: Establish baseline rates |  |  |  |
|  |  |  |  |
of diabetic patients in the registry with HbA1C > 9.0%  
Data Source: Chronic Disease Management Registry – which will be populated by the HIE

Process Milestone 3 Estimated Incentive Payment: $35,684

<table>
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<tr>
<th>Year Estimated Outcome Amount: $107,053</th>
<th>Year 2 Estimated Outcome Amount:</th>
<th>$248,176</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>$265,491</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>$265,491</th>
<th>Year 5 Estimated Outcome Amount:</th>
<th>$577,154</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,197,874**
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID:</td>
<td>085144601.3.7 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>University of Texas Health Science Center at San Antonio - John Roache and Pedro Delgado</td>
</tr>
<tr>
<td>TPI:</td>
<td>085144601</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

Outcome Measure 3.IT-3.8 seeks to reduce 30 day readmission rates. This can be done by assuring that accessible and effective outpatient programs exist to refer patients to upon discharge from the initial hospital visit and by integrating our program for seamless continuity of care follow-up for discharged patients. In DY2, three process milestones will begin to establish the STOP program envisioned as the accessible and effective outpatient treatment program. The goal of Project Planning (P-1) is to engage University Health System stakeholders and hire the program faculty and staff necessary to develop and establish the STOP program. Metrics include the recruitment of faculty and hiring of staff, and the development of program procedures and training plan, and integration of the STOP Program within University Health System Outpatient clinical programs. Success will be demonstrated through the documented achievement of these goals. We also will work with University Health System to Establish Baseline Rates (P-2) through data pulled from the EMR to track current rates of 30 day readmissions to the hospital or to the ER. Finally, we will Develop and Test Data Systems (P-3) capable of providing the outcome tracking necessary for the evaluation of program success. With these processes begun in DY2, two processes of DY3 will be devoted to evaluating and refining our program processes. First, we will conduct Plan-Do-Study-Act (PDSA) cycles (P-4) to evaluate our data collection processes for both the performance metrics within the STOP Program and from the hospitalization records of STOP Program patients. Our goal is to establish and improve the level of STOP Program operational success in treatment and hospital/ER visit prevention. Finally, it is critical to Disseminate Findings (P-5) to stakeholders and to identify lessons-learned and best practices to assure success. With STOP Program operations and performance metrics in place, DY3-DY4 will see further expansion of our patient care capacity through the addition of community provider trainees and continued program evaluation through PDSA cycle monitoring. Also in DY 4 and continuing through DY5, we can determine and improve upon the achievement of our Outcome Improvement Target to reduce readmission rates by at least 10% through effective STOP Program involvement.

**Rationale:**

Outcome Measure OD-3-IT-3.8 seeks to reduce 30 day readmission rates which for the STOP Program includes both inpatient admissions and ER visits. Readmission is understood to occur when ineffective initial treatment is given or when there is lack of efficacy for the follow-up treatment, or when there is lack of adherence to prescribed effective treatments. In the case of substance use disorder (SUD), neither hospitalization nor ER visits alone are considered effective treatment and therefore the critical feature is to have accessible and effective programs for post-discharge aftercare. Inadequate outpatient care infrastructure for adults with moderate behavioral health needs including substance abuse/dependence is well known and was identified in the Section III Needs Assessment Report. Also identified is the known reality that inadequate outpatient care programs result in unnecessary hospitalizations and Emergency Room visits. The STOP Program is designed to provide the outpatient continuum of care necessary for University
Health System to provide effective treatments and long-term relapse prevention using the evidence-based medication and non-medication treatments required to prevent ER visits and hospitalization. Successful rehabilitation and maintenance of relapse prevention through the STOP Program also will reduce unnecessary University Health System service utilization associated with comorbid disease deterioration.

**Outcome Measure Valuation:**

SUD is a chronically recurring disorder with a high risk of relapse that if left untreated, results in progressively more destructive patterns of disability, socioeconomic cost, and medical comorbidity. The STOP Program seeks to reduce hospital readmission by increasing the access to the continuum and continuity of care required to maximize treatment outcome and minimize the chances of full-blown relapse. Prevention of hospital visits for patients with SUD could save $1,000-2,000 per ER visit, $1,000-$3,000 per day of Hospital Admission. Of course the costs of trauma care and transplant services and the treatment of infectious diseases are much higher and effective outpatient treatment will also reduce these adverse outcomes. 3. Cost associated with preventing a single fatality related to DWI is estimated to be $3,300,000. There also are substantial cost savings in law enforcement and incarceration costs that could be considered in terms of community savings.
<table>
<thead>
<tr>
<th>085144601.3.7 PASS 1</th>
<th>3.IT-3.8</th>
<th>Behavioral health/substance abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>085144601.1.6</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD In DY 2</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 4</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
</tbody>
</table>
| [P-1]: Project Planning Goals: to establish STOP Program Metrics:  
- Develop treatment, training plan  
- Integrate within University Health System clinics  
- hire STOP Program staff; Data Source: RHP and STOP Program records of activity | [P-4]: Conduct PDSA cycles Goals: to utilize data-systems to inform and improve upon the STOP Program metrics Metrics: at least 3 cycles evidence review and actions taken to enact improvements. Data Source: STOP Program reports to RHP Anchor | Improvement Target: hospital readmissions within 30 days. Data Source: Hospital EMR reports for Hospital admissions. Outcome Improvement Target 1 Estimated Incentive Value: $238,942 | Improvement Target: hospital readmissions within 30 days. Data Source: Hospital EMR reports for Hospital admissions. Outcome Improvement Target 2 Estimated Incentive Value: $519,438 |
| **Process Milestone 2** | **Process Milestone 5** | **Outcome Improvement Target 1** | **Outcome Improvement Target 2** |
| [P-2]: Establish Baseline Rates Goals: To document current readmission rates for substance-related conditions. Metrics: analyze and identify base rates and critical EMR information to identify cases Data Source: hospital EMR | [P-5]: Disseminate Findings Goals: to communicate STOP Program metrics to RHP Anchor and other community partners who are stakeholders seeking to achieve Outcome Improvement. Metrics: STOP Program identifies Best Practices Data Source: STOP Program Reports and RHP records evidencing dissemination. | To reduce by 10%, hospital readmissions of preventable SUD patients compared to baseline. | To reduce hospital readmissions of SUD patients by 15% compared to baseline. |

**Outcome Improvement Target 2**

**Outcome Improvement Target 2 Estimated Incentive Value:** $519,438
| **Process Milestone 3**  
[P-3]: Develop and Test Data Systems  
Goals: Verify data pull from EMR and track STOP Program patient treatment outcomes.  
Metrics: Meaningful analysis and cost estimates of valid cases of hospital/ER visits and demonstration of treatment and retention of patients within STOP Program  
Data Source: STOP Program reports of analysis to University Health System.  
| Year 2 Estimated Outcome Amount: $96,347 | Year 3 Estimated Outcome Amount: $223,358 | Year 4 Estimated Outcome Amount: $238,942 | Year 5 Estimated Outcome Amount: $519,438 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,078,085**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP ID#: 085144601.3.8 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider target for improvement

1. Timely care, appointments, and information
2. Patient’s rating of doctor access to specialist

Process Milestones
DY2: P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeline and document implementation plan
DY3: P-2: Establish baseline rates for patient satisfaction

Improvement Targets
I-23 Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service

DY4: 5 percent over baseline
DY5: 10 percent over baseline

Rationale:
Providing patients with increased access to neurologic services leading to earlier intervention in patients with neurologic illnesses may prevent or slow deterioration or improve quality of life, and decrease the need for emergency department visits. Currently, the clinic is not adequately staffed to meet the ongoing needs of patients with neurologic diseases. Lack of timely access to a neurologist results in unnecessary visits to the emergency department often resulting in unnecessary admissions and/or increased length of stay for services that are not available in a timely fashion.

Outcome Measure Valuation:
Lack of timely access to a neurologist results in unnecessary visits to the emergency department often resulting in unnecessary admissions and/or increased length of stay for services that are not available in a timely fashion. Increased availability of outpatient neurologic services will result in reduced appointment waiting times, decreased ED utilization, and reduced lengths of stay.

The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
<table>
<thead>
<tr>
<th>085144601.3.8 PASS 1</th>
<th>3.IT-6.1 Percent improvement over baseline of patient satisfaction scores</th>
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<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
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<tr>
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<tr>
<td>Starting Point/Baseline:</td>
<td>TBD DY 2</td>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong>&lt;br&gt;P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans</td>
<td><strong>Milestone 2</strong>&lt;br&gt;P-2 Establish baseline rates&lt;br&gt;Data Source: Patient Satisfaction Survey&lt;br&gt;Milestone 2 Estimated Incentive Payment: $62,044</td>
<td><strong>Outcome Improvement</strong>&lt;br&gt;<strong>Target 1</strong>&lt;br&gt;IT-6.1 Percent improvement over baseline of patient satisfaction scores&lt;br&gt;Data Source: Patient Satisfaction Survey&lt;br&gt;Outcome Improvement Target 1: 5 percent&lt;br&gt;Estimated Incentive Payment: $66,373</td>
<td><strong>Outcome Improvement</strong>&lt;br&gt;<strong>Target 2</strong>&lt;br&gt;IT-6.1 Percent improvement over baseline of patient satisfaction scores&lt;br&gt;Data Source: Patient Satisfaction Survey&lt;br&gt;Outcome Improvement Target 1: 10 percent&lt;br&gt;Estimated Incentive Payment: $144,288</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $26,763</td>
<td>Year 3 Estimated Outcome Amount: $62,044</td>
<td>Year 4 Estimated Outcome Amount: $66,373</td>
<td>Year 5 Estimated Outcome Amount: $144,288</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $299,468**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-6.1 Percent improvement over baseline of patient satisfaction scores</th>
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<tr>
<td>Unique RHP ID#:</td>
<td>085144601.3.10 – PASS 1</td>
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<tr>
<td>Performing Provider:</td>
<td>University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>085144601</td>
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</tbody>
</table>

### Outcome Measure Description:

- Patient Satisfaction Scores for the following domains:
  1. Timely care, appointments, and information
  2. Patient rating of doctor access to specialist

### Process Milestones

- **DY2: P-1** Project planning – identify current capacity and needed resources, determine timeframes, and document implementation plans
- **DY3: P-2** Establish baseline rates for patient satisfaction

### Improvement Targets for DY3, DY4, and DY5:

- **DY4:** 5 percent over baseline
- **DY5:** 10 percent over baseline

### Rationale:

This outcome improvement target was selected to measure patient satisfaction with access to services.

### Outcome Measure Valuation:

Individuals with medical conditions affecting brain functioning often result in neuropsychiatric symptoms impaired cognitive abilities. Both of which are risk factor for decline in functional abilities. A decline in functional abilities affects patients’ ability to obtain/maintain employment resulting in lost productivity and work-related earnings.

The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment. The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
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</thead>
<tbody>
<tr>
<td>P-1 Project planning – identify current capacity and needed resources, determine timeframes, and document implementation plans</td>
<td>P-2 Establish baseline rates for patient satisfaction scores</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Data Source: Planning Documents</td>
<td>Data Source: Patient Satisfaction Survey</td>
<td>Data Source: Patient Satisfaction Survey</td>
<td>Data Source: Patient Satisfaction Survey</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $21,410</td>
<td>Process Milestone 2 Estimated Incentive Payment: $49,636</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $53,098</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $115,430</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $21,410</td>
<td>Year 3 Estimated Outcome Amount: $49,636</td>
<td>Year 4 Estimated Outcome Amount: $53,098</td>
<td>Year 5 Estimated Outcome Amount: $115,430</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $239,574**
Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID: 085144601.3.11 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: University of Texas Health Science Center at San Antonio (Dr. Julie Cowan Novak)</td>
</tr>
<tr>
<td>TPI: 085144601</td>
</tr>
</tbody>
</table>

Outcome Measure Description:

**DY 2** Develop Asthma outreach plan in order to effect appropriate utilization across Medicaid and indigent populations visiting the UTNCs

**DY 3** Define Asthma ED utilization baseline rate for those Medicaid and indigent patients visiting the UTNCs

**DY 4** IT-9.2 Improvement Target: ED appropriate utilization; Reduce Asthma ED visits by 10% over year DY 2 for established patients at the UTNCs who are Medicaid and or indigent.

**DY 5** IT-9.2 Improvement Target: ED appropriate utilization; Reduce Asthma ED visits by 20% over year 2 for established patients at the UTNCs who are Medicaid and or indigent.

Rationale:

In 2012, a survey from The Weather Channel and the Asthma and Allergy Foundation reported that San Antonio's spring allergy was the ninth worst in the nation, up from number 42 in 2011. Allergies, along with pollution, are triggers for asthma. The Medicaid and indigent populations are most susceptible to these triggers. One contributing factor is that the homes they occupy are not up to code for mold prevention; therefore, many of them live with the allergen triggers not only in the outside air, but in the places they reside.

According to the American Academy of Allergy, Asthma & Immunology (AAAAI), for the period 2007–2009 compared with adults, children had higher rates for asthma primary care and emergency department visits, similar hospitalization rates, and lower death rates from 2001 to 2009, health care visits for asthma per 100 persons with asthma declined in primary care settings, while asthma emergency department visit and hospitalization rates were stable. For the period 2008–2010, asthma prevalence was higher among children than adults. The number of people with asthma continues to grow. One in 12 people (about 25 million, or 8% of the U.S. population) had asthma in 2009, compared with 1 in 14 (about 20 million, or 7%) in 2001. More than half (53%) of people with asthma had an asthma attack in 2008. More children (57%) than adults (51%) had an attack. 185 children and 3,262 adults died from asthma in 2007.

As indicated, we will focus on keeping the asthma patients healthy and well-controlled in the primary care setting, thus reducing the ED visits and hospitalizations. In the baseline year, we will establish the status of our UTNC patients with asthma.

Outcome Measure Valuation:

Per the AAAAI, asthma cost the US about $3,300 per person with asthma each year from 2002 to 2007 in medical expenses, missed school and work days, and early deaths. Asthma costs in the US grew from about $53 billion in 2002 to about $56 billion in 2007. More than half (59%) of children and one-third (33%) of adults who had an asthma attack missed school or work because of asthma in
2008. On average, in 2008 children missed 4 days of school and adults missed 5 days of work because of asthma.

Untreated asthma will lead to more costly respiratory infections/illnesses, an increase in ED visits and hospitalizations, permanent narrowing of the airways, increased use of rescue medications, missed school days and getting behind in school, poor sleep and fatigue symptoms that interfere with play, sports and other activities that promote health and development.

Accessible, cost-effective primary care, patient/parent coaching and education will allow maintenance of asthma care patients. This project will enable the UTNC to reduce ED visits by 10% over the baseline in DY4 and by 20% in DY5.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and resources. Develop Asthma outreach plan to effect appropriate ED utilization for School of Nursing established Medicaid and indigent patients.</td>
<td>[P-2]: Establish baseline rates: Establish baseline rates of Asthma ED utilization for School of Nursing established Medicaid and indigent populations. Data Source: Electronic Medical Records, EPIC EHR and data analytics.</td>
<td>[IT-9.2] Improvement Target: ED appropriate utilization; Reduce Asthma ED visits by 10% over year 2 for Medicaid patients with Asthma. Data Source: Electronic Medical Records from RHP hospitals</td>
<td>[IT-9.2] Improvement Target: ED appropriate utilization; Reduce Asthma ED visits by 20% over year 2 for Medicaid patients with Asthma. Data Source: Electronic Medical Records from RHP hospitals</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $53,526</td>
<td>Year 2 Estimated Outcome Amount: $124,088</td>
<td>Estimated Incentive Payment: $132,745</td>
<td>Estimated Incentive Payment: $288,577</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $598,936
### Identifying Outcome Measure and Provider Information:

- **Title of Outcome Measure (Improvement Target):** IT 1.11 Diabetes care: BP control (<140/80mm Hg) NQF 0061 (Standalone measure)
- **Unique RHP ID:** 085144601.3.13 – PASS 1
- **Performing Provider Name:** University of Texas Health Science Center at San Antonio
- **TPI:** 085144601

### Outcome Measure Description:

Diabetes care: BP control (<140/90mm Hg)

- **Numerator:** Use automated Epic EHR to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- **Denominator:** Patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- **Data Source:** EHR, Registry

This outcome will be improved by 5% at the end of the waiver.

### Rationale:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. The known prevalence of diabetes in Bexar County is 10% and more than double for African Americans (14%) and Hispanics (13%) compared to 6% among Non-Hispanic Whites. Hispanics represent 54% of residents of RHP 6. These estimates do not account for undiagnosed diabetics and pre-diabetics. A highly functional primary care office in addition to increasing access will improve the quality of care for diabetics and hypertensives. The system changes needed to achieve this outcome will benefit both diabetic and hypertensive patients treated at these clinics with substantial savings preventing major complications from both diseases.

The process milestones selected are sequential and designed to address what we expect will be the major potential roadblocks to delivering this outcome goal and the practice engagement processes that will allow us to achieve this outcome. The initial project planning (P-1) will include an assessment of tools available for developing a registry of diabetics in Epic EHR, hiring a case management registered nurse for care management, and implementation of capture of data to populate diabetes registry. The second process milestone (P-2) establishing baseline rates will occur during DY2. The third process milestone (P-3) developing and testing data systems will occur during DY3, at the same time PDSA cycles will be implemented in each of the clinics (P-4) to implemented and test different interventions that will improve data collection and improve expected outcome measure.
### Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.

Achieves waiver goals (score 5): The project directly addresses waiver goals, with its objectives to assure that patients receive high-quality and patient-centered care in the most cost effective ways; improves health care infrastructure by expanding primary care and behavioral health access care access; further develops and maintains a coordinated care delivery system; and improves outcomes while containing cost growth by avoiding expensive emergency department visits and improving preventive and chronic disease care.

Addresses community needs (score 5): The project directly addresses multiple community needs including the recruitment and retention of a primary care workforce and thus addressing the shortage and access to primary care; addresses the need to have integrated behavioral health and primary care services; and directly addresses cardiovascular disease, cancer and diabetes, three of the top causes of death in the region.

Project Scope – (score 5) – By the end of this project, the region will have 10 additional primary care and behavioral health clinicians practicing in the community. The primary care capacity of UT Medicine will be increased by 25% to almost 50,000 unduplicated patients in all primary care clinics from a baseline of 39,818. A recently published article in Health Affairs provides us with an estimate of savings (Z. Song, D. G. Safran, B. E. Landon et al., “The ‘Alternative Quality Contract,’ Based on a Global Budget, Lowered Medical Spending and Improved Quality,” Health Affairs Web First, published online July 11, 2012.) Properly implemented changes similar to those proposed here provide savings as high as $22.58 per member per quarter. At the end of the project we expect to be caring for a panel of 9600 patients. At this rate the value in savings to the system could be as high as $867,072 at the final year in savings to the region.

Project Investment – (score 5) – The expected capital investment in human resources, lease, equipment, medical supplies, IT infrastructure and support, and time to implement is relatively large. The sustainability of the project is risky in that it requires a significant change in the payment structure for primary care from a fee-for-service only to a medical home blended payment similar to those implemented in other states.
<table>
<thead>
<tr>
<th>085144601.3.13 PASS 1</th>
<th>3.IT-1.11 Diabetes care: BP control (&lt;140/80mm Hg) NQF 0061 (Standalone measure)</th>
</tr>
</thead>
</table>

| University of Texas Health Science Center at San Antonio | TPI - 085144601 |

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Process Milestone 1**
[P1]: The initial Project Planning (P-1) will include an assessment of tools available for developing a registry of diabetics in Epic EHR, hiring a case management registered nurse for care management, and implementation of capture of data to populate diabetes registry.
Data Source: HR records, planning document including data capture plan.

Process Milestone 1 Estimated Incentive Payment: $45,498

**Process Milestone 2**
P-2: The second process milestone (P-2) Establishing Baseline Rates during first and second year
Data Source: Registry

Process Milestone 2 Estimated Incentive Payment: $105,475

**Process Milestone 3**
P-3: We will develop and test data systems. A manual check of a sample of 50 diabetics will be reviewed manually and compared with the results of the data captured by the diabetic registry, including the last BP recorded.
Goal/target: Get more than 80% agreement between data captured by registry and HER review by care manager.
Data Source: Epic EHR and data generated from diabetic registry

Process Milestone 3 Estimated Incentive Payment: $225,667

**Outcome Improvement Target 1**
[IT-1.11]: Diabetes care: BP control (<140/90mm Hg) NQF 0061
Improvement Target: Improve by 10% from baseline the number of diabetics that have blood pressure at less than 140/90.
Data Source: Diabetic registry, Epic EHR
Outcome Improvement Target 1 Estimated Incentive Payment: $225,667

**Outcome Improvement Target 2**
[IT-1.11]: Diabetes care: BP control (<140/90mm Hg) NQF 0061
Improvement Target: Improve by 20% from baseline the number of diabetics that have blood pressure at less than 140/90 from baseline.
Data Source: Diabetic registry, Epic EHR
Outcome Improvement Target 2 Estimated Incentive Payment: $490,581

**Process Milestone 4**
P-4: We will begin training and implementation of PDSA cycles to improve data collection and improve follow-

**Process Milestone 2**
P-2: The second process milestone (P-2) Establishing Baseline Rates during first and second year
Data Source: Registry

Process Milestone 2 Estimated Incentive Payment: $105,475

**Process Milestone 3**
P-3: We will develop and test data systems. A manual check of a sample of 50 diabetics will be reviewed manually and compared with the results of the data captured by the diabetic registry, including the last BP recorded.
Goal/target: Get more than 80% agreement between data captured by registry and HER review by care manager.
Data Source: Epic EHR and data generated from diabetic registry

Process Milestone 3 Estimated Incentive Payment: $225,667

**Outcome Improvement Target 1**
[IT-1.11]: Diabetes care: BP control (<140/90mm Hg) NQF 0061
Improvement Target: Improve by 10% from baseline the number of diabetics that have blood pressure at less than 140/90.
Data Source: Diabetic registry, Epic EHR
Outcome Improvement Target 1 Estimated Incentive Payment: $225,667

**Outcome Improvement Target 2**
[IT-1.11]: Diabetes care: BP control (<140/90mm Hg) NQF 0061
Improvement Target: Improve by 20% from baseline the number of diabetics that have blood pressure at less than 140/90 from baseline.
Data Source: Diabetic registry, Epic EHR
Outcome Improvement Target 2 Estimated Incentive Payment: $490,581
| Incentive Payment: $45,498 | up with diabetics who are not at target with blood pressure.  
Goal/target: Conduct two PDSA cycles to identify and intervene on diabetics who are not at target for blood pressure.  
Data Source: Charts and practice documentation of the PDSA cycle  
Process Milestone 4 Estimated Incentive Payment: $105,475 |
<table>
<thead>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $90,995</td>
<td>Year 3 Estimated Outcome Amount: $210,950</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,018,193**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-7.10  Proportion of children and adults with urgent dental care needs *(Stand alone measure)*
Unique RHP ID: 085144601.3.14 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:

Other Outcome Improvement Target
The evidence-based outcome is the increased % of dental emergency pain patients being treated by the dental provider.

Rationale:

We have selected IT-7.10. Other Outcome Improvement Target: Proportion of children and adults with urgent dental care needs *(Stand alone measure)*

a Numerator: Total number of patients seen by a new dental emergency clinic
b Denominator: Total Number of children and adults with urgent dental pain care needs
c Data Source: EHR, Claims
d Rationale/Evidence: patients are less likely to suffer from more severe, urgent oral health problems with adequate and regular access to dental care

- This outcome should be a priority for the RHP since it directly addresses a community need for emergency/urgent dental care. Data are described in the “Starting Point/Baseline” section, above.
- The proposed Category 1 project will help achieve this Category 3 outcome measure by providing emergency/urgent dental care to children and adult (including geriatric) patients. Thus, each patient treated contributes directly to the numerator for this Outcome Measure.

As described in the Category 1 template, our web-based survey indicates that low-income populations with moderate/severe health disparities comprise the majority of subjects contacting the UTHSCSA Dental Clinic with requests for access to emergency/urgent dental care. As of July 12, 2012, a total of 32,824 records have been entered by prospective patients. An analysis of this database indicates that there is a large unmet need for treating oral emergencies. Nearly 55% of the 32,824 records included patients who entered at least one of the following keywords indicative of a need for emergency/urgent care: “pain”, “ache”, “hurt”, “broken”, “toothache”, “emergency”, “swollen” or “swelling”. The process milestones and metrics as well as outcome improvement targets selected for this project are specifically designed to achieve designated outcomes to enhance dental care access for patients needing urgent care.

Two major conclusions emerge from this analysis. First, the UTHSCSA Dental School has a large catchment zone that includes broad representation across our community. However, the second finding is even more significant. The zip codes most frequently used by prospective emergency dental patients are highly linked to elevated scores on the Community Needs Index (CNI; see Fig 1 – Category I template). The CNI identifies the severity of health disparity for every zip code in the United States (5,6). It is a composite measure of income barriers, culture/language barriers, education barriers, insurance barriers and housing barriers. The CNI ranges from 1 (lowest socioeconomic barriers) to 5 (highest socio-economic barriers). There is >95% correlation between CNI scores and hospitalization rates, with admission rates for communities with CNI scores of 5 being ~60% greater than rates observed in communities with CNI scores of 1 (5). Importantly, the
mean CNI score for the top 20 zip codes in our database is 3.7. This analysis clearly demonstrates that there is strong need for an emergency dental clinic at UTHSCSA and that such a clinic will directly address populations with substantial health disparities.

References

Outcome Measure Valuation:

Achieves Waiver Goals (Self-Score =5): This project will develop a new dental care clinic for treating emergency/urgent care patients (process milestone) and provides new training and rotations for dental students and residents (process milestone). A recent study indicates that the cost of treating dental emergency patients in a dental clinic is about 10% of the cost of treatment provided in the ER (Graham et al., Ped Dent 22:134-140, 2000). Thus, this project addresses the Triple Aim by providing high quality and patient centered care in a cost effective manner (improvement outcome). Addresses Community Needs (Self-Score =5): An analysis of web-based contacts to the UTHSCSA Dental School by potential patients indicates that nearly 55% of the 32,824 patient contacts to the UTHSCSA Dental School requested emergency/ urgent care treatment. Project Scope (Self-Score = 4): This project scope is large in impact from four perspectives. First, it provides a new dental care clinic that does not currently exist (improvement outcome). Second, it will employ expanded hours to increase patient visits/encounters (improvement outcome). Third, it will involve training of both dental students and residents to treat these populations increasing the number of recruited/trained practitioners for the population living in the borders of RHP 6. (process milestone/improvement outcome) Fourth, it will provide savings from avoiding unnecessary ER visits. (improvement outcome). Project Investment (Self-Score = 5): This project involves human resources (faculty, staff, dental students, residents), new clinic space, new equipment and time to implement with an overall plan that integrates improvement and process to achieve the milestones.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 2</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(P-1] Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop plan for Emergency dental clinic, including training plan for residents and students. Data Source: Project plan Estimated Process Milestone Incentive Payment: $80,290</td>
<td>[P-2] Establish baseline rates. Metric 1 [P-2.1]: Identify proportion of children and adults with urgent dental care needs. Data Source: EHR Estimated Process Milestone Incentive Payment: $186,132</td>
<td>[IT-1.7.10]: Other Outcome Improvement Target: Proportion of children and adults with urgent dental care needs Improvement Target: Increase proportion of treated children and adults with urgent dental care needs by 50% over DY3 baseline rate. Thus, we plan on treating a total of 1,800 patients. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $199,118</td>
<td>[IT-1.7.10]: Other Outcome Improvement Target: Proportion of children and adults with urgent dental care needs Improvement Target: Increase proportion of treated children and adults with urgent dental care needs baseline values. Thus, we plan on treating 3,492 patients. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $432,865</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline: To be determined in DY2</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $898,405
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-7.10 Other Outcome Improvement Target: Enhance quality assessment of dental care via use of information technology. *(Proposed Standalone measure)*

Unique RHP ID: 085144601.3.15 – PASS 1
Performing Provider: University of Texas health Science Center at San Antonio;
TPI: 085144601

Outcome Measure Description:
The Dental EHR will serve as a data source to measure milestones for the project. The system contains patient record information, clinic schedules, transactional history for both patients and providers, billing information, consent forms and clinical notes. Dental School faculty and staff in the office of Patient Care/Information technology will be responsible for the implementation of the project and for the training of all the Dental School workforce providers involved in the delivery of patient care in the various general and specialty clinics. At the end of the project, we expect to achieve a 10% increase in the number of specialized data elements, queries, and reports that will be used in the Quality Improvement processes for patients treated in the DS and off-site clinics.

PROCESS MILESTONES DY 2 AND DY 3:

- P-1 Project Planning-engage stakeholders identify current capacity and needed resources.
- P-2 Establish baseline rates
- P-3 Develop and test data
- P-4 Conduct plan, do Study Acts (PDSA) cycles to improve data collection & intervention activities
- P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- P-7 Other activities described below:

Process milestones are essential to the planning process and to enable us to establish parameters and protocols essential to assessing clinical quality outcomes, patient safety and treatment effectiveness. Patient satisfaction surveys will assist in measuring timeliness, appropriateness and satisfaction with care and care experience. Reference to P-1: a clinical informatics curriculum will be established in order to train and calibrate all providers and staff on the use of Certified Electronic Record. Treatment outcomes assessments that are based on standards of care will be performed on patients of the dental school and the aggregate data analysis will identify needs for improvement based on established targets.

The category 3 Outcome target relates to the implementation of the certified electronic record training of all faculty, students and staff involved in patient care throughout all of the Dental School general and specialty clinics, including outreach facilities using the same clinic information system and analysis of patient data to support clinical quality measures. Each year, we will have a new cohort of students, including general and specialty residents as well as new faculty or staff who will require training. This information will enable us to make necessary changes to improve oral health quality and achieve efficiency in the system. Our benchmark for compliance will be 85% after year 3 implementation with goal of 95-100% compliance in year 4. This will enable us to share standardized data with other US dental schools using certified systems.
Rationale:
We have selected IT-7.10. Other Outcome Improvement Target: In order to evaluate treatment outcomes, a comprehensive EHR with specialized designated data elements need to be implemented. Software (acquired via EHR Incentive Program) that has Core CMS quality measures that support meaningful use of HIT, hardware, network systems and workforce IT training along with the ability to add customized data elements, helps to provide the infrastructure (human and technological resources) necessary for patient care quality improvement. This can be used to compare against benchmarks and to indicate that standards have been met to attain quality improvement.
a Numerator: Number of DS faculty, students, residents and staff trained in use of Certified EHR
b Denominator: Total number of faculty, students, residents and staff involved in patient care delivery at the Dental School and Off-campus sites
c Data Source: Training logs/schedules; training materials
Rationale/Evidence: The ability to impact the effectiveness, timeliness and appropriateness of care within the UTHSCSA dental school and its’ off-campus sites which serve the general population of the Region, including low-income populations and have the capacity to share this information with other providers of health care services and dental educators is critical to maintaining the quality of dental educational institutions. (Fontaine et al).

Outcome Measure Valuation:
Outcome Measure (proposed): Enhance quality assessment of dental care via use of information technology. This project is intended to provide the information infrastructure needed to assess patient care and ensure that patients treated at the Dental School and off-site clinics receive high quality, patient-centered dental care in a cost effective and efficient manner; and that the dental care is coordinated and that better dental care outcomes are attained for all dental school patients, including the uninsured, Medicaid and CHIP as well as Title V and special needs patients. The DS will implement and train the dental school faculty, staff, dental/dental hygiene students and residents in the use of the certified electronic record with the CMS quality core measures added. Through this project, we will track dental treatment outcomes, cost savings, efficiency of dental care delivery and referral systems within dental school to specialty departments, reduction in dental errors/prosthetic replacements, measure student performance, provide broad array of clinical experiences required to train dentists, dental hygienists, and dental specialists to be competent practitioners, and identify gaps in training needs.

Achieves Waiver goals: this project focuses on assuring that patients receive high-quality care through monitoring treatment via use of the certified electronic health record. It improves the oral health care infrastructure to better serve all patients, including Medicaid patients and will enable the DS to further develop and maintain an internal coordinated care delivery system. The implementation of this project is expected to improve oral health outcomes while containing cost and minimizing unneeded treatment. This project will also impact the DS urgent care clinic, facilitating reporting and standardization and impacts all patients treated by the DS. The evidence supports implementation of the Certified EHR addresses Community Needs: this project supports all of the DS treatment programs and is expected to provide real-time evidence regarding treatment outcomes for patients, including the underserved and uninsured, many of whom seek treatment in the DS. Project Scope: Patient visits/encounters will be tracked for all patients along with clinical core measures, providers will be trained and savings are anticipated due to better coordination of comprehensive dental care. Project Investment: this project involves
human resources (faculty, staff, dental students, residents), new clinic facility, new equipment and time to implement with an overall plan that integrates improvement and process to achieve the milestones.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop IT training plan and curriculum; train key clinic and IT support personnel, including faculty, students, &amp; staff. Data Source: Training schedules Goal: Curriculum Developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-2]: Establish Baseline Rates Metric 1: P-2.1: Baseline Data established on number of faculty, staff, students, and residents trained Source: axiUm training schedules Goal: Personnel trained</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 (IT-7.10) Enhance quality assessment of dental care via use of information technology Metric 1: Providers utilizing additionally programmed features on certified EHR system (85%) Data Source: AxiUm (EHR) Outcome Improvement Goal: Data points utilized Target 1 Estimated Incentive Payment: $62,044</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 (IT-7.10) Enhance quality assessment of dental care via use of information technology Metric 1: Providers utilizing additionally programmed features on certified EHR system (100%) Data Source: AxiUm (EHR) Outcome Improvement Goal: Data points utilized Target 1 Estimated Incentive Payment: $66,373</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $26,763</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $62,044</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $66,373</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $144,288</td>
</tr>
<tr>
<td>Starting Point/Baseline: TBD in DY 2</td>
</tr>
<tr>
<td>The University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $26,763</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 299,468</strong></td>
</tr>
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</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.3 Pediatric/young adult asthma emergency department visits-NQF 1381
Unique RHP ID: 085144601.3.18 – PASS 1
Provider Name: University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:

Outcome Measures: Improved primary health care for asthma and lead exposed children by: (a) Reducing emergency department visits by 65%, reducing hospitalizations by 81%; reducing school days missed by 39%; reducing parents’ work days missed by 49%; increasing the use of written care providers Asthma Action Plans by 71%; increasing parent lead/asthma health care literacy survey score by 50% and improving health quality of life survey scores for lead asthma patients and providers by 50%. (B) Assessing environmental triggers for asthma and lead; (C) educating the parent provider on home remediation techniques; (c) facilitating Medicaid health care enrollment through assistance from assigned health navigator; (d) assessing neuropsychological growth and development pathology secondary to asthma & lead exposures; (e) Performing environmental health inspections for mold, CO2, lead, dust mites and pet dander.

Rationale:

Reason for Selecting Process Milestone: The selected milestones are research-based milestones documented in the U.S. Housing and Urban Development and in Centers for Diseases Control and Prevention policy and public documents. The units of analysis are reduced identified patients hospital visits and reduced school absents to improve cognitive, behavioral, psychosocial & mental health of the identified child. Improved health knowledge and parental compliance in child health management, continued enrollment in Medicaid, and enhanced knowledge via health education to make environmental hygienic changes in the home to reduce asthma triggers.

Outcome Measure Valuation:

Approach for Valuing Outcome measure: (a) Medical chart review will be conducted to assess number of sick day visits pre-program intervention, at 3, 6 and 12 intervention time periods; (b) School attendance records (sick days) will be reviewed at baseline entry, 3, 6 and 12 months; (c) Quality of life, Asthma and other health indicators of lead exposure (to include biomarker data) will be collected at baseline, 6 months and 12 months; (d) Parent completed child behavior checklist (psychosocial measure) will be conducted at baseline, 6 months and 12 months. A total of 372 family units, approximately 1,488 subjects, will be served at clinic and home visitation sessions. Home inspections, education, home remediation suggestions and environmental measures will be collected at baseline, 6 and 12 months.
<table>
<thead>
<tr>
<th>085144601.3.18 PASS 1</th>
<th>3.IT-9.3</th>
<th>Pediatric/Young Adult Asthma Emergency Department Visits-NQF 1381</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 2</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Process Milestone 1 [P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Conduct medical chart review to assess number of sick day visits, E.R visits, biomarker laboratory reports, neuropsychological reports pre-program intervention</th>
<th>Data Source: S.A.GHHI database and Medical records</th>
<th>Estimated Incentive Payment: $69,584</th>
</tr>
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<tbody>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates-Measure ED baseline visit rates for program participants.</td>
<td>Data Source: Program participant medical records.</td>
<td>Estimated Incentive Payment: $161,314</td>
</tr>
<tr>
<td>Outcome Improvement Target 1</td>
<td>IT-9.3: Reduction in ED visits within program participant population</td>
<td>Goal: TBD</td>
<td>Estimated Incentive Payment: $172,570</td>
</tr>
<tr>
<td>Outcome Improvement Target 2</td>
<td>IT-9.3: Reduction in ED visits within program participant population</td>
<td>Goal: TBD</td>
<td>Estimated Incentive Payment: $375,150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Outcome Improvement Target 1</th>
<th>Improvement Target 1 Estimated Incentive Payment: $172,570</th>
</tr>
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<tbody>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Outcome Improvement Target 2</td>
<td>Improvement Target 2 Estimated Incentive Payment: $375,150</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $69,584</td>
<td>Year 3 Estimated Outcome Amount: $161,314</td>
<td>Year 4 Estimated Outcome Amount: $172,570</td>
</tr>
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<td>---------------------------------------------</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $778,618**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-2.4 Behavioral Health / substance abuse admission rate |
| Unique RHP Outcome Identifier: | 085144601.3.19 – PASS 1 |
| Performing Provider: | The University of Texas Health Science Center at San Antonio |
| TPI: | 085144601 |

### Outcome Measure Description:

The major outcome will be Potentially Preventable Admissions (PPA) to psychiatric hospitals for the target population (Children with ADHD with severe comorbidities). We estimate that our target populations will have 80-120 such preventable admissions a year; we seek to reduce this by 20%. Decrease in hospitalization will be the outcome measure in years 4 and 5. This estimate is based on our clinical experience that half of these hospitalizations are related to acute crisis/lack of access to outpatient care and could be avoided with through PROXIMA. The other half of hospitalizations are due to severe mental illness and require inpatient stabilization.

### Rationale:

- Psychiatric hospitalizations of children with ADHD and complex comorbidities (aggression, mood disorder) have risen dramatically in Texas. These admissions occur in crisis and rarely result in long term outpatient care to consolidate any gains. Thus, there is often little long term benefit despite high costs. (We seek to reduce psychiatric hospital admission by 50% over baseline rates).
- PROXIMA will seek to reduce potentially preventable admissions (PPA, OD-2) through provision of integrated mental/physical health services. Improved outcome for children with ADHD with integrated care has been shown by numerous studies (http://www.skipproject.org/)
- Process Milestones for Outcome: **Milestone 1** will be to engage stakeholders (pediatricians, community) to ensure PROXIMA program meets the challenges these families present. **Milestone 2** will establish the baseline rate of psychiatric hospitalization. This is a customized milestone critical to accurate assessment of our Improvement Target. **Milestone 3** will be to test data collection procedures, while **Milestone 4** will be to conduct Plan Do Study Act (PDSA). We choose reduced hospitalization as our Improvement Target due to the high cost of hospitalization and the lack of evidence that acute hospitalization improves long term functioning.

### Outcome Measure Valuation:

The project valuation section state the project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.
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<tbody>
<tr>
<td>[P-1]:  Project Planning, engage stakeholders, identify current capacity, determine timelines, document implementation. Data Source: Survey of providers and families regarding needs of children with severe ADHD Process Milestone 1 Estimated Incentive Payment: $32,116</td>
<td>Process Milestone 3 [P-3]: Develop and test data. Design mechanisms to track patients, monitor crisis, improve response time to families to detect crisis before hospitalization Data Source: EHR, project data Process Milestone 3 Estimated Incentive Payment: $74,453</td>
<td>Outcome Improvement Target 1 [IT-2.4]: Behavioral health / substance abuse admission rate Improvement Target: 15% reduction in hospitalization rate relative to baseline Data Source: Claims data Outcome Improvement Target 1 Estimated Incentive Payment: $159,294</td>
<td>Outcome Improvement Target 2 [IT-2.4]: Behavioral health / substance abuse admission rate Improvement Target: 20% reduction in hospitalization rate relative to baseline Data Source: Claims data Outcome Improvement Target 2 Estimated Incentive Payment: $346,292</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $718,724**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health/Substance abuse 30 day readmission rate  
Unique RHP ID: 085144601.3.20 – PASS 1  
Provider Name: The University of Texas Health Science Center at San Antonio  
TPI: 085144601 |

### Outcome Measure Description:

Process Milestones include project planning to determine current capacity and needed resources, establishing baseline rates based on hospital discharge and readmission data, developing and testing data systems, and conducting Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Process milestones and PDSA cycles monthly will focus on steps needed in preventing readmissions to hospital for behavioral health reasons. Improvement Goal is Behavioral Health readmission rate. Our goal is to reduce the readmission rate by 20% by year 3 and 30% in year 4.

### Rationale:

With respect to our process milestones, we have selected a planning phase to identify the current capacity of the TCC and determine the needs for training and clinical care based upon input from the community. We are in constant contact with hospitals to improve communication and services. We will also work to establish baseline rates based upon data from participating hospitals regarding readmission rates within 30 days. This will require collecting and merging data from a variety of sources to ensure that appropriate cases are counted. We will develop and test data systems to support our analysis of outcomes. We work closely with our data management staff to ensure that HIPPA compliant data systems can generate needed reports. Finally, we have extensive experience using PDSA to improve treatment delivery and patient outcomes in community mental health for SMI. We have been able to use this approach in numerous ways to improve outcomes (e.g. ensuring providers follow guidelines for monitoring metabolic syndrome in community mental health). With respect to outcome improvement targets, re-hospitalization was selected because hospitalization is the single most costly intervention for individuals with behavioral health diagnoses and preventing readmission and ED diversions is a primary goal of the community. The TCC will achieve this goal by providing rapid access to care and multiple ebps including medication management, Cognitive Adaptation Training, Cognitive Behavior Therapy, and Case coordination. Our own published research demonstrates a reduction of up to 45% in 9 month readmission rates for individuals in wrap-around care versus standard care. While the TCC focuses on only the 3 months post-hospital period, this is the most critical period with continuing care provided by connecting individuals to existing community services. Reductions of 20% and 30% in DY4 and DY5 are based on the shorter length of time we will have working with these individuals versus our published reports. Focusing on preventing readmission will allow rapid and evidence-based treatment in the community where individuals have maximal independence and costs of care are lower.

### Outcome Measure Valuation:

Rehospitalization and emergency room revisit rates from Major Hinchman 2010 study yield the cost lack of care coordination between inpatient/ED and outpatient settings as well as of the delay in accessing care. We also used demonstrated savings from our pilot program for Superior Medicaid of $20,000/patient in hospital costs per year. The PDSA, includes collection of data from various hospitals and emergency departments as well as maintaining a data base and documenting the quality improvement process.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>085144601.2.3</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 2</td>
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</table>

### Year 2

**085144601.3.20 PASS 1 3.IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate**

<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-1 Project Planning]: [Engage stakeholders identify current capacity and needed resources determine timelines and document implementation plans]</td>
<td>[P-3]: [Test data systems] Data Source: data system, outputs and reports</td>
<td>[IT-3.8]: Behavioral Health Admission rate. Improvement Target: Reduce 30 day readmissions to hospital by 15% from baseline. Data Source: Electronic medical record at the University Hospital System, reports from other hospitals and ERs, patient report</td>
<td>Year 2 Estimated Outcome Amount: $107,053</td>
</tr>
<tr>
<td>Data Source: meeting minutes, completed assessment, form versions, updates to shared drive, monthly progress reports</td>
<td>Process Milestone 3 Estimated Incentive Payment $124,088</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $53,527</td>
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</tbody>
</table>

### Year 3

<table>
<thead>
<tr>
<th>Process Milestone 2</th>
<th>Process Milestone 4</th>
<th>Outcome Improvement Target 1 Estimated Incentive Payment: $124,088</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-2]: [Establish baseline rates] Data Source: Department annual report on hospitalizations, data from local hospitals, training records)</td>
<td>[P-4]: [Conduct PDSA cycles to improve data collection and intervention activities] Data Source: form versions, updates to shared drive, monthly reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $53,527</td>
<td>Process Milestone 4 Estimated Incentive Payment $124,088</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $107,053</td>
<td>Year 3 Estimated Outcome Amount: $248,176</td>
<td>Year 4 Estimated Outcome Amount: $265,491</td>
</tr>
</tbody>
</table>

### Year 4

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 Estimated Incentive Payment: $577,154</th>
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<tbody>
<tr>
<td>[IT-3.8]: Behavioral Health Admission rate. Improvement Target: Reduce 30 day readmissions to hospital by 20% from baseline. Data Source: Electronic medical record at the University Hospital System, reports from other hospitals and ERs, patient report</td>
</tr>
</tbody>
</table>

### Year 5

<table>
<thead>
<tr>
<th>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,197,874</th>
</tr>
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</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,197,874
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%)
Unique RHP ID#: 085144601.3.21 – PASS 1
Performing Provider: University of Texas Health Science Center at San Antonio
Performing Provider TPI: 085144601

Outcome Measure Description:

DY2
The process milestones for this year are designed to lay the groundwork for our chronic disease management program. Milestone P-3 will reflect our development of a comprehensive care management program for diabetes and hypertension based on principles of the CCM. The milestone will be implemented by a practice improvement team meeting weekly. The team will include physicians, nurses, medical assistants, pharmacists, social work, and a practice facilitator with experience in practice change towards CCM. The team will assemble and adapt evidence-based protocols from the literature on CCM implementations in primary care. As the evidence-based protocols are assembled, we will train the relevant staff (Milestone P-2) in the CCM. We will also be working with our health system to create EHR reports tracking HbA1c levels and blood pressure readings for patients with diabetes mellitus and hypertension. Milestones P-2 and P-3 will establish baseline rates for the diabetes improvement milestone and develop and test data systems for creating a valid patient cohort based on the outcome measures and for reporting diabetes outcomes for these patients.

DY3
The process milestones for this year will add CCM components to increase the comprehensiveness of our approach. These include P-1 Document Implementation Plans: Develop and implement a plan to help patients self-manage their chronic conditions. DY3 also includes our improvement Milestone I-17 in which we identify our first cohort of 200 patients with poorly controlled diabetes for inclusion in our disease registry and CCM interventions as determined by the planning process. As program implementation begins, we will also implement PDSA cycles testing iterative small improvements in our intervention.

DY4
Milestones for this year include scaling up process and improvement milestones from DY3, so that more patients are included in the CCM registry and intervention, more participate in self-management and more participate in group visits. In addition, in DY4 we will introduce our Category 3 milestones:
IT 1.10 Diabetes care: HbA1c poor control. We have determined the baseline rate for HbA1c>9% to be 25% in our population. Our goal for this milestone is to reduce it to 22.55 in DY4.
We will continue to increase the numbers of patients participating in the intervention and to further decrease the prevalence of HbA1c >9%.
The goal for HbA1c >9% is less than 17.5% absolute prevalence among patients with diabetes in the CCM program.

Rationale:
The process milestones were selected to create a logical flow from planning, to developing an overall CCM approach, to developing specific elements supporting the CCM (Hroscikoski et al, Ann Fam Med 2006;4:317). The selected Category 3 outcome measure is IT 1.10 HbA1c poor control (>9%). We chose this measure because our system-wide assessments reveal that the
prevalence of poor control is high in our population. Although not all interventions based on the chronic care model are successful (e.g. Landon et al, NEJM 2007:356) a recent review concludes that the CCM has, overall, helped guide successful interventions and improved outcomes (Coleman et al, Health Affairs 2009:75.) In our low-income population with poor health care access, we anticipate that improved connections to effective care and self-management support will decrease the proportion of patients with poorly controlled diabetes (Liebman et al, Diab Educ 2007;33:132S).

Although HbA1c is an intermediate outcome rather than a direct measure of morbidity/mortality, it is very strongly associated with the latter (Wei et al, Diab Care 119;21:1167) and reductions in HbA1c reduce macrovascular and microvascular complications although data demonstrate that overly intensive treatment of glycemic levels is associated with increased risk (Kelly et al, Ann Intern Med. 2009;151:394-403).

**Outcome Measure Valuation:**
The outcome selected (glycemic control for patients at highest levels of HbA1c) has strong evidence tying it to reduced complications, improved quality of life, and lower health care costs. The intervention framework and interventions have also been extensively studied and applied in the target population, with evidence of benefit for the Category 3 outcomes. For example, the short-term health care savings from lowering HbA1c values higher than 9-10% is approximately $1500 per patient, based on the literature cited above. This does not account for reducing the longer-term prevention of complications.
### Diabetes care: HbA1c poor control (>9.0%)

<table>
<thead>
<tr>
<th>085144601.3.21</th>
<th>3.IT-1.10</th>
<th>University of Texas Health Science Center at San Antonio</th>
<th>TPI-085144601</th>
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<tr>
<td>PASS 1</td>
<td></td>
<td>Related Category 1 or 2 Projects: 085144601.2.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Starting Point/Baseline: Baseline level: 25% of patients with diabetes have HbA1c above 9%; BP baseline TBD</td>
<td></td>
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</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
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</tbody>
</table>

**Process Milestone 1**

P-1 – Project Planning:
- Document implementation plans: Develop a comprehensive care management program
- Metric 1: Documentation of a care management program based on Wagner's Chronic Care Model
- Baseline/Goal: Baseline of no plan documented to goal of approved care management plan
- Data Source: Program Materials including approved care management plan

**Process Milestone 2**

P-2: Establish baseline values for improvement outcome indicator: Poor control of diabetes with HbA1c values >9%.

**Process Milestone 3**

P-3 Develop and test data systems: Test reporting systems for HbA1c.
- Metric 1 P-3: Create valid reports for glycemic control.
  - Goal: Monthly reports that are sensitive and specific with respect to eligible patients and associated readings.
  - Data source: Electronic program files.
  - Rationale: Eligible patients and relevant readings must be identified with excellent sensitivity and specificity from EHR queries.

**Process Milestone 4**

P-3 Develop and test data systems: Create registries for patients with diabetes to be enrolled in the CCM project.
- Goal: Create data fields for a working registry to be populated.
- Data source: documentation of eligible patients and relevant readings.

**Outcome Improvement Target 1**

IT-1.10: Decrease the % of adult patients with poor control of HbA1c.
- Metric 1: % of practice patients age 18-75 with diabetes mellitus with HbA1c>9%.
  - Baseline: 25%
  - Goal: 22.5%
  - Data Source: EHR data.
  - Rationale: Poorly controlled glycemia is associated with a high burden of diabetes complications, hospitalizations, and costs.

**Outcome Improvement Target 2**

IT-1.10: Decrease the % of adult patients with poor control of HbA1c.
- Metric 1: % of practice patients age 18-75 with diabetes mellitus with HbA1c>9%.
  - Baseline: 22.5%
  - Goal: 17.5%
  - Data Source: EHR data.
  - Rationale: Poorly controlled glycemia is associated with a high burden of diabetes complications, hospitalizations, and costs.

**Milestone 1 Estimated Incentive Payment:** $7,137

**Milestone 2 Estimated Incentive Payment:** $26,549

**Milestone 3 Estimated Incentive Payment:** $57,716
<table>
<thead>
<tr>
<th>Metric: reports on practice denominator of adults with diabetes and numerator of adults with HbA1c values &gt;9%. Data source: EHR.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $7,137</td>
</tr>
</tbody>
</table>

**Process Milestone 3**

P-3 Develop and test data systems: Defining a cohort of clinic patients for CCM. 

Metric 1 P-3: Create a valid database of patients eligible for CCM program. 
Goal: A database of eligible patients. 
Data source: Electronic program files. 
Rationale: Eligible patients must be identified with excellent sensitivity and specificity from EHR queries. 
Milestone 3 Estimated Incentive Payment: $7,137

**Milestone 5**

P-1 – Project Planning: 
Document implementation plans: Develop a plan for patient self-management to be implemented by nurse care managers in collaboration with other practice staff. 
comprehensive care management program 

Metric 1: Documentation of a patient management program based on Lorig’s self-management model 
Baseline/Goal: Baseline of no plan documented to goal of approved patient self-management plan 
Data Source: Program Materials including approved self-management plan. 
Milestone 5 Estimated Incentive Payment: $24,817
<table>
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<tr>
<th>Year</th>
<th>Estimated Outcome Amount</th>
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</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>$21,411</td>
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<tr>
<td>Year 3</td>
<td>$49,635</td>
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<tr>
<td>Year 4</td>
<td>$26,549</td>
</tr>
<tr>
<td>Year 5</td>
<td>$57,716</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $155,311
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%)</th>
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<tbody>
<tr>
<td>Unique RHP ID# 085144601.3.22 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider Name: University of Texas Health Science Center at San Antonio</td>
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<tr>
<td>TPI: 085144601</td>
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**Outcome Measure Description:**

Here we describe Category 3 Process and Improvement Milestones.

**DY2**

P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Here we begin by establishing criteria for selecting patients for CHW services. We also develop work routines for collaboration of CHWs and members of the health care team: meeting frequency, attendance, appropriate modes of communication through voice, email, text, and EHR, and record keeping. The metric for P-1 is written documentation for the planning and protocols described.

**DY3**

P-4 Conduct PDSA cycles. In this year, as CHW begin work with our patient panel we will hold weekly meetings of CHWs and clinical staff to review successes, stumbling blocks, and needed additional supports. Using PDSA methodology, we will iteratively frame small tests of improvement and evaluate the results. The metric for P-4 is meeting records and summaries of improvement projects.

P-3 Develop and test data systems. We will work with our health system IT personnel to develop routine monthly reports on patients with diabetes from our panel that will capture HbA1c levels, ambulatory visits (to identify patients not having regular visits), ED visits (to identify patients with critical disconnects from care), and hospital admissions (to identify patients with complications). The metric for P-3 will be monthly data reports from the patient panel of glycosylated hemoglobin levels, patients exceeding the threshold of 9%, and patients in the cohort working with CHWs who have ED visits or admissions.

**DY4**

P-4 Conduct PDSA cycles. In this year, as CHW begin work with our patient panel we will hold weekly meetings of CHWs and clinical staff to review successes, stumbling blocks, and needed additional supports. Using PDSA methodology, we will iteratively frame small tests of improvement and evaluate the results.

IT-1.10, % of patients with poor control of HbA1c.

**Metric 1** % of practice patients age 18-75 with diabetes mellitus with HbA1c>9%.

- Baseline: 25.5%
- Goal: 22.5%

Data Source: EHR data.

**DY5**

IT-1.10, % of patients with poor control of HbA1c.
Metric 1  % of practice patients age 18-75 with diabetes mellitus with HbA1c>9%.
Baseline: 22.5%
Goal: 17.5%
Data Source: EHR data.

Rationale:
Our Category 3 improvement target and valuation is based on the following considerations: there is strong evidence that moving patients from poor to fair or good glycemic control (a) reduces diabetes complications such as coronary disease, stroke, and renal failure; (b) decreases hospitalizations, and health care costs, and (c) improves patients’ quality of life. This evidence is briefly summarized and quantified below.

In recent years, data from UKPDS and other studies have led to a reconsideration of the utility and safety of aggressive glucose targets in type 2 diabetes. Our goal in this project is therefore to reduce the prevalence of markedly abnormal glycemic control, which we define as HBA1c >9%. Ample evidence documents the micro- and macro-vascular morbidity associated with uncontrolled diabetes. For example, persons with diabetes in a community-based cohort study (Atherosclerotic Risk in Communities) in the highest Hba1c quintile (A1c>8.2%) had a 2.8 fold increased risk of coronary heart disease events (on a baseline of 14.4%) compared with those in the lowest quintile (Selvin et al, Arch Int Med 2005). In a secondary analysis of data from the HOPE study, a randomized drug trial, a 1% rise in the Hba1c level was associated with a 7% increase in the risk of cardiovascular events, a 20% increase in the risk of hospitalization for heart failure, a 12% increase in total mortality risk, and a 26% increase in risk of overt nephropathy. Risks increased nonlinearly, with steeper increases in patients in the top 2 deciles of A1c (A1c >8.9%)(Gerstein, Diabetologia 2005). An observational study from the Fallon Clinic showed poor glycemic control (A1c >10%) was associated with a high risk of hospitalization -- 31 per 100 per year, twice that of patients with fair control (A1c 8-10%). Mean adjusted hospital charges were also twice as high ($3040 vs. $1380/year; in 1998 dollars) (Menzin et al, Diabetes Care 2001). A larger follow-up study from 2010 in the same system confirmed the findings: annual costs for diabetes-related hospitalizations were $3278 with Hba1c of 7-8%, $4029 at 8-9%, $4963 at 9-10%, and $6759 when the A1c exceeded 10% (Menzin et al, J Managed Care Pharm 2010). And the Group Health Cooperative of Puget Sound, found that reductions in Hba1c from a mean of 10% were associated with annual savings of $680-950 (in 1997 dollars). (Wagner et al, JAMA 2001).
Improved glycemic control also improves quality of life. A randomized trial of intensified glycemic control (from mean Hba1c of 9.3% to 7.5%) examining patients’ functional outcomes, such as quality of life, work participation, bed-days, and restricted activity days, demonstrated substantial improvements in a wide range of QOL and activity measures (Testa, JAMA 2008).

The evidence base supporting this CHW intervention derives from a variety of CCM interventions that are being adapted for low-income populations (e.g. Epping-Jordan et al, Qual Saf Health Care 2004;13:299–305; Lorig et al, Nurs Res 2003;52:361). In many of these models, CHWs collaborate closely with nurse care managers to deliver assessment and education in the home setting when patients have barriers limiting travel to the health center.

In this project the CHW role encompasses 3 models of care defined in the Community Health
Worker National Workforce Study (HRSA 2007): member of care delivery team, navigator, and organizer. These models, which the report noted were not mutually exclusive, consist of working under the direction of clinicians (physicians or nurses), helping patients navigate complex health systems, and working in communities to promote self-directed change and community development (HRSA 2007).

The process milestones for CHW’s unique patients served were estimated at follows. Our CHW model calls for assessments and teaching in the patients’ homes so as to provide data on contextual influences such as neighborhood setting for diet and physical activity, or family situations that interfere with self-management. We therefore estimate CHW’s will make 8 visits per week x 50 wks or 400 visits per year per FTE. Conservatively estimating 5 visits per year per unique patient to allow for both assessment and self-management training, each CHW FTE will manage 80 unique patients per year. We allow for 50% capacity in the first year after hire. With 3 CHW hired in year 1 and 3 additional CHW hired in year 2, the target numbers for unique patients served in DY3/4/5 are thus 180/540/720.

Outcome Measure Valuation:
The outcome selected (glycemic control for patients at highest levels of HbA1c) has strong evidence tying it to reduced complications, improved quality of life, and lower health care costs. Please see “Rationale” immediately above for details. The intervention mechanism has also been extensively studied and applied in the target population, with evidence of benefit for the Category 3 outcome. For example, the short-term health care savings from lowering HbA1c values higher than 9-10% is approximately $1500 per patient, based on the literature cited above. This does not account for reducing the longer-term prevention of complications.
<table>
<thead>
<tr>
<th>085144601.3.22 PASS 1</th>
<th>3.IT-1.10</th>
<th>Diabetes care: HbA1c poor control (&gt;9.0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>085144601.2.5</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline level: 25% of patients with diabetes have HbA1c above 9%;</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 3</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>P-1 Project planning – document implementation plans: Establishing criteria for CHW services.</td>
<td>P-3 Develop and test data systems: Defining a cohort of clinic patients eligible for CHW services.</td>
<td>IT-1.10: % of patients with poor control of HbA1c.</td>
</tr>
<tr>
<td><strong>Metric 1 P-1.1:</strong> Establish specific criteria defining patient selection for inclusion in the CHW program.</td>
<td><strong>Metric 1 P-3.1:</strong> Create a valid database of patients eligible for CHW program.</td>
<td><strong>Metric 1 [I-1.2]:</strong> % of practice patients age 18-75 with diabetes mellitus with HbA1c&gt;9%.</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Process Milestone 4</strong></td>
<td><strong>Outcome Improvement Target 1</strong> Estimated incentive payment: $37,468</td>
</tr>
<tr>
<td>P-1 Project planning: Identify current capacity and needed resources: Develop work routines for CHW collaborations with primary care teams (meeting frequency,</td>
<td>P-4 Conduct PDSA cycles to improve data collection and intervention activities. <strong>Metric P-4.1</strong> Documentation of suggested improvements and results from implementation</td>
<td>Estimated incentive payment: $86,861</td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong></td>
<td><strong>Process Milestone 4</strong></td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $185,843</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated incentive payment:</strong> $37,468</td>
<td><strong>Process Milestone 4 Estimated incentive payment:</strong> $185,843</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $185,843</td>
</tr>
</tbody>
</table>
modes of verbal and written communication, record keeping).

**Metric 1: P-1.2:** Written guidelines for CHW collaborations with primary care team.

Goal: written documentation of operating procedures for team collaboration with CHWs.

Data source: Program documents.

Rationale: Working relationships with new CHW members of the health care team must be clearly specified to promote effective collaborations in both directions.

Process Milestone 2 Estimated incentive payment: $37,468

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $74,937</th>
<th>Year 3 Estimated Outcome Amount: $173,723</th>
<th>Year 4 Estimated Outcome Amount: $185,843</th>
<th>Year 5 Estimated Outcome Amount: $202,004</th>
</tr>
</thead>
</table>

Tests.  
Goal: Weekly tests of small improvements in patient outreach mechanisms, patient assessments, navigation strategies, collaboration with team, and other activities.

Data source: Program and meeting records. Summarized quarterly.

Rationale: Frequent small tests of improvement are necessary to improve and optimize project performance.

Process Milestone 4 Estimated incentive payment: $86,861

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $838,511**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-10.1 (Quality of Life) |
| Unique RHP Identification Number: | 085144601.3.23 – PASS 2 |
| Provider Name: | University Health Science Center at San Antonio |
| TPI: | 085144601 |

### Outcome Measure Description:

In general our goal for individuals with hearing loss that is significantly interfering with their ability to communicate and generally enjoy life, is to enable them through appropriate assessment and intervention including use of appropriate hearing aids and supportive counseling, to hear more of the sounds around them and better understand speech in a range of situations. In short, our goal is to help them increase all communication-related activities (World Health Organization). To assess the benefit derived from amplification and the resultant reduction in hearing handicap and improved life quality, we will administer three brief questionnaires, prior to intervention (at the time of initial assessment) and following intervention (30 -45 days after the initial fitting of amplification and initial communication counseling). Three standardized self-assessment measures will be used: The Client Oriented Scale of Improvement (COSI); The 10 item Hearing Handicap Inventory for the Elderly Screening Version (HHIE),( Ventry & Weinstein, 1982) which assess both the social and emotional impact of hearing loss on the individual, and the 15 item Satisfaction with Amplification in Daily Life scale (SADL) (Cox and Alexander, 1999), which assess positive effect comprised of decreased communication disability, improved self-confidence, improved sound quality, and overall assessment of worth; service and cost, comprising reliability, clinician competence, and cost; negative features comprised of reaction to background sounds, feedback, and the hearing aid’s usefulness on the telephone; and personal image, comprised of appearance and the apparent reaction of others. Pre and post measures will be taken to assess reduction in hearing handicap and increase in communication ability and overall satisfaction and improvement in life quality. 80-85 % of patients served with hearing aids and support services through the Drop In Hearing Clinic will report improvement in quality of life/hearing handicap reduction scores as measured via the standardized HHIE and the SADL self-assessment inventories.

### Rationale:

At the current time a significant barrier to access to hearing health care is lack of proximity of care, inappropriate level of care (entering the hearing health care system at a more costly level of triage/care, and cost), and high cost of care. This project addresses these current barriers. Appropriate intervention for hearing loss and medical ear problems will both improve health status through primary prevention, appropriate identification of and referral for intervention for ear disease, as well as reduction of the impact of hearing loss, on the ability of individuals in this group to achieve communication independence and more fully function in society. In short; to more effectively claim their unalienable rights to life, liberty and the pursuit of happiness.
Outcome Measure Valuation:

The value of this project is in its creation of a new model for hearing health care delivery that incorporates both new and existing personnel and new and existing health care facilities in multi-level hearing health care assessment/treatment model designed to address the gross disparity in percentage of adults with hearing loss receiving hearing health care services versus all who need those services. Consistent with the definition of health care “value” as health outcomes per dollar spent, it is designed to provide more convenient patient access to lower cost effective hearing health care resulting in improved hearing/communication ability for an increased percentage of those who need effective hearing health care. The model acknowledges that a significant percentage of this population has sensorineural hearing loss that is essentially bilaterally symmetrical, often noise-induced, with no other medically-related hearing/balance complications and who primarily need assessment of their hearing and appropriate fitting/adjustment of digital signal processing hearing aid technology delivered and supported as close to their neighborhood as possible. A smaller percentage of the adult hard of hearing population needs more extensive audiology and medical services. They are in need of triage from the Drop-In Hearing Clinic with referral to the next level of audiology/medical care. A goal of this project is to demonstrate an approach to the “right care, each time for each patient” for individuals entering the hearing health care system with the ultimate goal of improving the quality of life for each patient served through appropriate intervention and ultimately hearing handicap reduction. This triage and referral process would be accomplished through the Drop-In Hearing Clinic access point staffed by remote community audiologists participating in the Drop-In Hearing Clinic Network, working in conjunction with onsite Teleaudiology Clinical Technician students whom they supervise. Next-level referrals would be facilitated to network audiology/ENT providers who the patients identify as located conveniently to them and/or who has the most immediate ability to schedule a next-level hearing health care appointment for the patient. This would enable the patient to begin the referral relationship facilitated at the Drop-In Hearing Clinic site.

The scope of this pilot project is limited to 1 site: UTHSCSA Student/Employee Health Clinic with audiology faculty and their Au.D. students providing the remote audiology services from the UTHSCSA MARC, University Health Systems Audiology Department; or UT-Austin Department of Communication Sciences and Disorders Audiology Clinic in conjunction with TCT course students from the UTHSCSA School of Nursing or other professional degree programs. This scope is designed to bring hearing health care services to UTHSCSA students and employees and their families at a central campus location. Project outcomes for providers include: Up to 15 joint UT-Austin/UTHSCSA Doctor of Audiology students will complete clinical rotations among the CECSD hearing/balance consortium partners in the San Antonio region including delivery of audiology services under faculty supervision in the Drop-In Teleaudiology Clinic; 15 to30 UTHSCSA nursing or other professional degree (e.g. PA) students will complete the Teleaudiology Clinical Course and engage in teleaudiology clinical service delivery under supervision in the Drop-In Hearing Clinic. Project outcomes for patients: 700 adult patients will be served at the Drop In Hearing Clinic locations and either provided with high performance mini-BTE hearing aids or appropriately referred to the next level of hearing health care.
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Milestone 3</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1: Project planning: Providers will engage the stakeholders:</td>
<td>P-3: Develop and test data systems</td>
<td>Process Milestone 3 Estimated Incentive Payment: $11,952 $55,501</td>
<td>IT-10.1 - Quality of Life: Demonstrate improvement in quality of life (QOL) scores as measured by evidence based and validated assessment tool for quality of life. The goals of this project are to develop an innovative teleaudiology hearing health care delivery model that enables screening, assessment and triage of individuals complaining of hearing loss and balance problems with appropriate treatment at that level of care and/or referral to the next level of care. Relative to 10.1 Quality of Life: the goal is to achieve and document success in reducing perceived hearing handicap and thus improve quality of life related to improved ability to hear and communicate through appropriate intervention</td>
<td>IT-10.1 - Quality of Life, subsequent improvement in achievement of target outcome goals will be indicated by a. Quality of Life as assessed using The Hearing Handicap Inventory for Adults/Elderly-Screening (HHIE-S) Satisfaction With Amplification in Daily Living (SADL) and Client Oriented Scale of Improvement (COSI) tools will be used to assess each patients self-perceived hearing handicap and hearing handicap reduction and improved communication function and related improvement in quality of life with the use of hearing aids and support counseling delivered in the program.</td>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Outcome Improvement Target 2 Estimated Incentive Payment:** $129,372

**Data Source:**
HHIE-S, SADL and COSI assessment instruments.

**Outcome Improvement Target 2 Estimated Incentive Payment:** $129,372
been involved in the initial planning of the joint program and the preceptorship rotations of the 3rd and 4th year Au.D. students. The UTHSCSA School of Nursing Student/Employee Health Vice Dean for Practice and nursing faculty/staff. have all been engaged in initial discussions regarding the development of onsite Telehealth Drop In Hearing Clinic to be staffed by UTSHCASA MARC audiologists and UT-Austin audiology faculty/students and UTHSCSA ENT residents and faculty. The Drop In Hearing Clinic will serve UTHSCSA faculty/students/staff and their families. $1.4 million in STARS funding has been secured and equipment is being ordered equip the Drop in Hearing Clinic at UTHSCSA and to expand audiology equipment /space infrastructure at UTHSCSA to support audiology student education and expanded telehealth clinical service delivery

Process Milestone 2 Estimated Incentive Payment: $11,952

Milestone 2  
P-2: Establish baseline regarding:  
a. the number of UT-Austin Au.D. students who will enter into the 3rd/4th joint UT-Austin/UTHSCSA CECSD (including hearing aids) and counseling delivered via telehealth and in person (as needed) by audiology students and supervising faculty audiologists and ENT residents and supervising ENT faculty with the support of students who are enrolled in the TCT course who are learning TCT skills necessary to support teleaudiology /teleENT practice. Quality of Life improvement and related hearing handicap reduction will be assessed prior to treatment for each individual with hearing loss entering the innovative hearing health care delivery system, and at regular intervals during and upon completion of treatment appropriate to each patient. Impact of hearing amplification on hearing handicap reduction and quality of life improvement will be assessed using the Hearing Handicap Inventory for Adult/Elderly-Screening (HHIE) and the Satisfaction with Amplification in Daily Living) SADL and the Client Oriented Scale of Improvement (COSI)
Preceptorship rotations and initiate those placement and rotations
b. the number of UTHSCSA School of Nursing and other professional degree students who will enroll in the TCT course and initiate course delivery with coordination with Doctor of Audiology student education and actual patient service delivery using teleaudiology at the Drop In Hearing Clinic.
c. determination of the number of individuals, using questionnaire/survey methods, among those served by student and employee health clinics at UTHSCSA who indicate some degree of hearing handicap (using the Hearing Handicap Inventory for Adults/Elderly-Screening HHIE-S) as a screening questionnaire, who desire help for their hearing loss, who may or may not be currently wearing hearing aids and their current satisfaction with their hearing aids (using the Satisfaction with Amplification in Daily Living (SADL) assessment tool. Advertise the availability of the new Drop in Hearing Clinic

Process Milestone 2 Estimated Incentive Payment: $11,952

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Outcome Amount</th>
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<tbody>
<tr>
<td>Year 2</td>
<td>$23,904</td>
</tr>
<tr>
<td>Year 3</td>
<td>$55,501</td>
</tr>
<tr>
<td>Year 4</td>
<td>$59,584</td>
</tr>
<tr>
<td>Year 5</td>
<td>$129,372</td>
</tr>
</tbody>
</table>
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $268,361
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.4 Other outcome improvement target
Unique RHP Outcome ID: 085144601.3.24 – PASS 2
University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:

Outcome Measure: “Other outcome improvement target.” This project’s intent is to implement cancer telemedicine conferences to underserved communities.

Process milestones and improvement targets: We are projecting an increase in the number of cancer telemedicine conferences by 30% over baseline, to serve this region.

Quality: Process Milestones. P-1: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Establish Multidisciplinary cancer specialty telemedicine conferences serving a broad section of underserved areas in South Texas. Goals/Rationale: Implement multidisciplinary cancer specialty telemedicine conferences serving underserved population areas in South Texas. Goals/Rationale: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Establish Multidisciplinary cancer specialty telemedicine conferences serving underserved areas in South Texas. Goals/Rationale: Implement and test telemedicine videoconferencing equipment at specific sites, establish standard operating procedures for the videoconference; complete signed agreements for process and privacy; conduct tutorials for staff accessing this program. P-4: Conduct Plan-Do-Study-Act (PDSA) Cycles to improve data collection and intervention activities. Metric: Implement high quality multidisciplinary specialty cancer-care videoconferences to serve the needs of the population in underserved areas of South Texas. Goals/Rationale: PDSA cycles are widely accepted methods of continuous quality improvement. PDSA cycles quarterly will be used to demonstrate improvement in quality of specialty cancer care videoconferences in underserved areas. PLAN: Implement ideal multidisciplinary videoconferencing for specialty cancer care in underserved areas. DO: Equip all target underserved sites with videoconferencing tools and outline SOPs. STUDY: Quality of Conferences and Provider Satisfaction Surveys. ACT: Update format of conferences and equipment needs to suit ideal needs of the target population in underserved areas.

To achieve continuous quality improvement we shall assess the project’s impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

Rationale:

Cancer is a leading public health issue in Texas (It is the number one cause of death for children in Texas age 1-14, and the leading cause of death for people in Texas age 85 or younger). In the absence of effective communication, providers of cancer-care are forced to refer patients to tertiary care centers, and the patients and public are forced to travel enormous distances to tertiary-care cancer centers at significant cost to their quality of life and financial health. Communication methods like telemedicine can improve cancer healthcare by enhancing cancer-related decision-making and motivate action to improve the quality of cancer care in underserved areas. The CTRC is committed to enhancing Cancer-Telemedicine to communities in underserved areas of South Texas by expanding use of telehealth to provide expert multidisciplinary cancer conferences and Tumor Boards to improve access to evidence-based cancer decision-making across the disease spectrum from prevention to survivorship and end of life care. Increase the percent of providers in underserved areas of South Texas accessing specialty cancer-care consultations by cancer
telemedicine by 25% over baseline; and of patients in those areas receiving tertiary cancer-care by telehealth in their own communities by 30% over baseline by Year-3 of implementation.

**Outcome Measure Valuation:**

Cancer is a huge burden in Texas and it is important to point out that Cancer is the leading cause of death among Hispanics in the US—the largest and fastest growing minority group in the US. With 20% of all Hispanics in the US residing in Texas, we will need to prepare for 1 in 2 Hispanic men, and 1 in 3 Hispanic women being diagnosed with cancer, and the lifetime probability of dying from cancer is 1 in 5 for Hispanic men and 1 in 6 for Hispanic women (American Cancer Society, Cancer Facts and Figures for Hispanics and Latinos 2012-2014), we will need to enhance the access to specialty cancer-care using telemedicine and for this population. In addition, there are projected to be nearly 12 million cancer survivors by 2020, >60% of whom are age >65—it is critical, therefore, to use the best technology to provide immediate access to specialty cancer-care across all areas of Texas urban and rural using telemedicine to deal with this magnitude of elderly cancer survivors who will need care, surveillance, and efforts to promote healthy aging (Parry C et al., Cancer Epidemiol Biomarkers Prev 2011;20:1996-2005).
<table>
<thead>
<tr>
<th><strong>085144601.3.24</strong>&lt;br&gt;PASS 2</th>
<th><strong>3.IT-9.4</strong></th>
<th>Other outcome improvement target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>University of Texas Health Science Center at San Antonio</strong></td>
<td><strong>085144601.1.16</strong></td>
<td><strong>TPI - 085144601</strong></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
<td></td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>The CTRC has established strong collaborative partnerships to provide cancer telehealth services and virtual Tumor Boards with cancer health providers and communities in Laredo, Harlingen, Edinburgh, with plans to extend services to Del Rio, Eagle Pass, Carizo Springs, Victoria, and Hondo. Video-conferencing using Webex communication has been successfully tested for links to Laredo and Harlingen. Dr. Karnad has made trips to Harlingen and to Laredo with CTRC teams to establish cancer telemedicine conferences and tumor boards in formats most acceptable to the communities served, and highlighting specific cancer types common in those communities (hepatocellular carcinoma) or for expert consultation on uncommon cancers (leukemia and hematological cancers).</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Establish Multidisciplinary cancer specialty telemedicine conferences serving a broad section of underserved areas in South Texas. Numerator: Number of new unique cancer-care telemedicine video-conferences serving specific underserved areas in South Texas. Denominator: Currently established cancer-care telemedicine video-conferences</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-1: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Establish Multidisciplinary cancer specialty telemedicine conferences serving a broad section of underserved areas in South Texas. Numerator: Number of new unique cancer-care telemedicine video-conferences serving specific underserved areas in South Texas. Denominator: Currently established cancer-care telemedicine video-conferences</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;(IT-9.4): Increasing the number of underserved areas from 3 to 5. Data Source: CTRC referral processing system for electronic tumor boards. Outcome Improvement Target 2 Estimated Incentive Payment: $89,375</td>
<td><strong>Outcome Improvement Target 3</strong>&lt;br&gt;(IT-9.4): Increasing the number of underserved areas from 5 to 7. Data Source: CTRC referral processing system for electronic tumor boards. Outcome Improvement Target 3 Estimated Incentive Payment: $194,058</td>
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<table>
<thead>
<tr>
<th>Process Milestone 1 Estimated Incentive Payment: $35,856</th>
<th>Process Milestone 2 Estimated Incentive Payment: $41,626</th>
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<tr>
<td><strong>Outcome Improvement</strong></td>
<td><strong>Target 1</strong></td>
</tr>
<tr>
<td>(IT-9.4): Increasing the number of underserved areas from 1 to 3.</td>
<td>Data Source: CTRC referral processing system for electronic tumor boards.</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $41,626</td>
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| Year 2 Estimated Milestone Bundle Amount: $35,856 | Year 3 Estimated Milestone Bundle Amount: $83,251 | Year 4 Estimated Milestone Bundle Amount: $89,375 | Year 5 Estimated Milestone Bundle Amount: $194,058 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $402,541**
<table>
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<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
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<tbody>
<tr>
<td><strong>Title of Outcome Measure (Improvement Target):</strong> IT- 9.4 Other Outcome Improvement Target</td>
</tr>
<tr>
<td><strong>Unique RHP ID:</strong> 085144601.3.25 – PASS 2</td>
</tr>
<tr>
<td><strong>Performing Provider:</strong> University of Texas Health Science Center at San Antonio</td>
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<tr>
<td><strong>TPI:</strong> 085144601</td>
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<tr>
<th><strong>Outcome Measure Description:</strong></th>
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<tbody>
<tr>
<td><strong>Outcome Measure:</strong> “Other outcome improvement target.” This project’s intent is to increase trained oncology providers to serve the underserved population with or at-risk for cancer in South Texas who have been identified as being at significant cancer health disparity in that region.</td>
</tr>
</tbody>
</table>

Process milestones and improvement targets: We are projecting an increase in the number of new oncology trainees by 25% over baseline, to serve this region.

Process Milestones: The following will be applied: P-1: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Percentage of current trainees providing cancer-care in underserved and rural areas. Goals/Rationale: Implementing training for hematology-oncology fellows to serve in underserved areas with cultural competency curricula and skills will enhance specialty care in underserved areas as nearly 80% of trainees stay in Texas after training. Accreditation bodies such as the ACGME, and UTHSCSA GME will need to be engaged to approve innovative curricula, approve increase in training slots. Finally, Memoranda of Understanding will need to be in place between the training program and the individual underserved institutions and clinical training sites. P-4: Conduct Plan-Do-Study-Act (PDSA) Cycles to improve data collection and intervention activities. Metric: Improve the curriculum of cancer-care for underserved population in combination with cultural competency education. PDSA cycles are widely accepted methods of continuous quality improvement. PDSA cycles q 6 months will be used to demonstrate improvement in training quality in underserved areas. The following PDSA format will be used PLAN: Design and Implement Curricula and Cultural Competency Skills Education and Evaluation. DO: 6-month blocks of rotations in underserved areas. STUDY: Pre- and Post-Test scores. ACT: Revise curriculum based on target scores

<table>
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<tr>
<th><strong>Rationale:</strong></th>
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<tr>
<td>The main reason for selecting this project is the overwhelming burden of cancer affecting our population in Texas—cancer is the leading cause of death in this state, coupled with serious shortage of trained oncology providers—Texas ranks 45th in the nation in the number of physicians per population: Therefore, we would like to educate the next generation of cancer care providers especially medical oncologists who can provide ideal cancer care from cancer prevention to survivorship care in rural and underserved areas of South Texas. This is one of the highest priorities for the NCI-designated Cancer Center, the CTRC. We would like to increase the capacity to provide cancer care and oncology specialty care services and the availability of highly trained specialty providers to better accommodate the high demand for cancer care and oncology specialty care so that patients have efficient and effective access to such services in their own community</td>
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<thead>
<tr>
<th><strong>Outcome Measure Valuation:</strong></th>
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</thead>
</table>
| Cancer is a huge burden in Texas and it is important to point out that Cancer is the leading cause of death among Hispanics in the US—the largest and fastest growing minority group in the US. With 20% of all Hispanics in the US residing in Texas, we will need to prepare for 1 in 2 Hispanic men, and 1 in 3 Hispanic women being diagnosed with cancer, and the lifetime probability of dying from
cancer is 1 in 5 for Hispanic men and 1 in 6 for Hispanic women (American Cancer Society, Cancer Facts and Figures for Hispanics and Latinos 2012-2014), we will need to enhance the number and quality of trained oncologists to serve this population. In addition, there are projected to be nearly 12 million cancer survivors by 2020, >60% of whom are age >65—it is critical, therefore, to prepare a workforce to deal with this magnitude of elderly cancer survivors who will need care, surveillance, and efforts to promote healthy aging (Parry C et al., Cancer Epidemiol Biomarkers Prev 2011;20:1996-2005)
Starting Point/Baseline: Texas Medical Association (TMA) data show that physicians who complete both medical school and GME in the state are almost three times more likely to practice in Texas. Our own data on training oncologists from 2004-2012 in our ACGME accredited training program at the UT Health Science Center demonstrates the following: 19 of the total of 26 (73%) oncologists who graduated from our program in this period stayed in Texas upon graduating, and of those, 17 (89%) are still practicing in Texas.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td><strong>Outcome Improvement Target 3</strong></td>
</tr>
<tr>
<td>P-1: Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Percentage of current trainees providing cancer-care for underserved and rural areas. Numerator: Number of trainees assigned to rural underserved centers. Denominator: Total number of approved trainees in the hematology-oncology training program. Data Source: Graduate Medical Education Data: ACGME, UTHSCSA GME. Goals/Rationale: Implementing training for hematology-</td>
<td>P-4: Conduct Plan-Do-Study-Act (PDSA) Cycles to improve data collection and intervention activities. Metric: Improve the curriculum of cancer-care for underserved population in combination with cultural competency education. Numerator: Implementation and Evaluation of Specifically designed training curriculum for cancer care in underserved areas with built-in cultural competency skill education and evaluation. Denominator: Comprehensive hematology-oncology 3-year training program. Data Source: 6-monthly evaluation system by the training program on each</td>
<td>IT-9.4: Increase the number of fellows serving in outreach clinics in underserved areas from 2 to 4. Increasing the number of clinics served by hematology/oncology trainees in underserved areas from 3 to 5. Data Source: CTRC GME records for hematology/oncology trainees.</td>
<td>IT-9.4: Increase the number of fellows serving in outreach clinics in underserved areas from 4 to 6. Increasing the number of clinics served by hematology/oncology trainees in underserved areas from 5 to 7. Data Source: CTRC GME records for hematology/oncology trainees.</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $59,584</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong> $129,372</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
oncology fellows to serve in underserved areas with cultural competency curricula and skills will enhance specialty care in underserved areas as nearly 80% of trainees stay in Texas after training.

Process Milestone 1 Estimated Incentive Payment: $23,904

<table>
<thead>
<tr>
<th>Goals/Rationale:</th>
<th>PDSA cycles are widely accepted methods of continuous quality improvement. PDSA cycles q 6 months will be used to demonstrate improvement in training quality in underserved areas.</th>
</tr>
</thead>
</table>

Process Milestone 2 Estimated Incentive Payment: $27,750

**Outcome Improvement**

**Target 1**

(IT-9.4): Increase the number of fellows serving in outreach clinics in underserved areas from 0 to 2. Increasing the number of clinics served by hematology/oncology trainees in underserved areas from 1 to 3.

Data Source: CTRC GME records for hematology/oncology trainees

Outcome Improvement Target 1 Estimated Incentive Payment: $27,750

| Year 2 Estimated Milestone Bundle Amount: | $23,904 | Year 3 Estimated Milestone Bundle Amount: | $55,501 | Year 4 Estimated Milestone Bundle Amount: | $59,584 | Year 5 Estimated Milestone Bundle Amount: | $129,372 |
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $268,361
<table>
<thead>
<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Outcome Measure (Improvement Target):</strong> IT 6.1-Percent Improvement Over Baseline of Patient Satisfaction Scores (Pediatric Specialty Care Network)</td>
</tr>
<tr>
<td><strong>Unique RHP ID:</strong> 085144601.3.27 – PASS 2</td>
</tr>
<tr>
<td><strong>Performing Provider:</strong> University of Texas Health Science Center at San Antonio; Pediatric Cardiology, Pediatric Dermatology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Neurology, Pediatric Pulmonology</td>
</tr>
<tr>
<td><strong>TPI 085144601</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome Measure Description:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>IT 6.1 Patient satisfaction will be measured throughout the process. Baseline data will be collected from a sample of patients in each specialty area in DY1. Survey elements will include:</td>
</tr>
<tr>
<td>A) Patient/parent impression of ease of access to specialist and timeliness of appointment</td>
</tr>
<tr>
<td>B) Patient/parent impression of the quality of physician communication.</td>
</tr>
<tr>
<td>C) Patient/parent impression of involvement in shared decision making.</td>
</tr>
<tr>
<td>The information collected through the survey process will be reviewed continually throughout the process. Quarterly feedback will be given to providers (physicians and NPs) in the specialty care clinics and to the clinic leadership. Individual specialty clinic sites will be empowered to adopt changes to improve patient satisfaction. Successful improvements will be shared formally throughout the Specialty Care network semi-annually through a Learning Collaborative model.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rationale:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The milestones chosen are to assure that the access expansion improves service to the children and families of greater San Antonio and the other areas in RHP6 that use San Antonio for pediatric specialty care. Additionally, collecting information about “Third Next Available Appointment” and Patient Satisfaction will allow us to assure that access is fairly distributed throughout the community. The Patient Satisfaction information will allow assurance that the other important characteristics of the patient experience are also fairly distributed throughout the community to assure that all of the specialty clinic sites provide a high quality service and that the outreach sites compare favorably with the care delivered in the main, central clinic.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome Measure Valuation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall target goal is to establish a network of pediatric specialty care clinics throughout greater San Antonio which will enhance the ability for all children in San Antonio and the surrounding region to have timely and convenient access to pediatric specialty care. Overall health of the children of the region will be enhanced through effective delivery of care and effective communication with referring practitioners through the use of modern EMR application. These improvements will enhance access for all children to the new children's hospital and will support the addition of needed pediatric specialty care providers.</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>[IT-1.1]: Using the information collected in the Patient Satisfaction survey, improvements will be made throughout the process. This will occur through a Learning Collaborative design internal to the Pediatric Specialty providers (physicians and NPs) and the staff supporting the clinic.</td>
</tr>
<tr>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Data Source: Developed survey</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $277,504</td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 3</strong></td>
</tr>
<tr>
<td>[IT-1.1]: Using the information collected in the Patient Satisfaction survey, improvements will be made throughout the process. This will occur through a Learning Collaborative design internal to the Pediatric Specialty providers (physicians and NPs) and the staff supporting the clinic.</td>
</tr>
<tr>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Data Source: Developed survey</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $646,862</td>
</tr>
</tbody>
</table>
**Milestone 2 Estimated Incentive Payment:** $59,760

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Outcome Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>$119,520</td>
</tr>
<tr>
<td>Year 3</td>
<td>$277,504</td>
</tr>
<tr>
<td>Year 4</td>
<td>$297,918</td>
</tr>
<tr>
<td>Year 5</td>
<td>$646,862</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,341,804
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores.
Unique RHP ID: 085144601.3.29 – PASS 2
Performing Provider Name: University of Texas Health Science Center at San Antonio
TPI: 085144601

Outcome Measure Description:
Process Milestones DY 2: P-X- Project planning, where we will engage stakeholders (providers and employees). P-5: Enhance the organizational infrastructure and resources to store, analyze, and share patient experience data, as utilize them for quality improvement; Process Milestones DY 3: P-X: Develop and implement a training program on patient experience; Process Milestones DY 4: (P-X) Continue to assess patient experience scores and utilize results to develop quality improvement projects; Process Milestone DY 5: Process Milestone 6 (P-X): Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency, and other issues aligned with continuous process improvement.

Rationale:

We selected the Category 3 stand alone outcome domain of Patient Satisfaction. Research has shown that patient care experiences positively correlate to clinical quality processes and outcomes on both the practice and provider levels\(^\text{142}\). Additionally, patients with better care experiences are more engaged and adherent, and have better health outcomes. For example, a recent study in the *Journal of Family Practice* demonstrated that adherence rates were 2.6 times higher among primary care patients whose providers had “whole person knowledge” of them compared to patients of providers without that knowledge\(^\text{143}\). This translates to better, more cost effective healthcare and healthier patients.

There are also other financial implications to consider, in the form of incentives, lower malpractice risk, and increased patient loyalty. Increasingly, patient experience is being tied to financial incentives, as is the case in Massachusetts and California\(^\text{144}\). And with the passage of the new healthcare law, Centers for Medicare and Medicaid Services (CMS) will be making mandatory the implementation and reporting of patient experience survey results, and tying these measures to financial incentives\(^\text{145}\). We will most likely be monetarily penalized for not collecting and reporting on this data. The implementation of CG-CAHPS now puts us in the


position to have better scores once we are mandated to report them publicly.

Tracking patient experience data is cost efficient in other ways. The Journal of the American Medical Association\(^{146}\) has published several articles demonstrating that good patient experience correlates with lower medical malpractice risk\(^{147}\). In fact, a 2009 study found that with each drop in patient-reported score along a five-step scale from “very good” to “very poor”, the likelihood of being named in a malpractice suit increased by 21.7%\(^{148}\). Measuring patient experience using the CG-CAHPS and with the assistance of NRC Picker Service alerts is a hands-on approach for identifying and addressing issues in care that could lead to lawsuits.

Lastly, it is well known that patients keep or change providers based upon experience. Relationship quality is a key predictor of patient loyalty\(^{149}\), and in Bexar County where patients have many choices for their healthcare needs, they can vote with their feet.

### Outcome Measure Valuation:
Implementing CG-CAHPS is a low-cost project that serves not only the current patients of UTHSCSA, but future patients as well. A sampling of 50 responses per provider per year (8750 responses total, per year) ensures that many different patient populations are heard.

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\(^{148}\) Fullam F, Garman AN, Johnson TJ, and Hedberg EC. The use of patient satisfaction surveys and alternate coding procedures to predict malpractice risk. Medical Care 47 (5).

### Related Category 1 or 2 Projects:

#### Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Process Milestone 1
**P-1: Project planning- engage stakeholders**

- Metric: Internal communication from CEO regarding launching of CG-CAHPS survey project. Discussion of project at Medical Director’s meetings.
- Data Source: Internal communication, meeting minutes/agenda
- Goal: Providers and employees are aware of the new initiative
- Process Milestone Estimated Incentive Payment: $23,904

#### Process Milestone 2
**P-2: Establish Baseline rates**

- Metric: CG-CAHPS survey results. 1 if completed, 0 if not.
- Data Source: CG-CAHPS survey results
- Goal: Baseline data collected.
- Process Milestone Estimated Incentive Payment: $27,750

#### Process Milestone 3
**P-5: Dissemination of findings**

- Metric: Communication to providers and employees of baseline results
- Data Source: Internal communication, Screenshot of online reporting system
- Goal: Providers are able to access their results online to see baseline data.
- Process Milestone Estimated Incentive Payment: 27,750

#### Outcome Improvement Target 1
**IT-6.1: 2.5% improvement over baseline of patient satisfaction scores in the following area: patient’s involvement in shared decision making**

- Metric: Numerator: percent improvement in targeted domain
- Data Source: patient survey
- Outcome Improvement Target Estimated Incentive Payment: $59,584

#### Outcome Improvement Target 2
**IT-6.1: 3% improvement over baseline in patient satisfaction scores in the following area: patient’s involvement in shared decision making**

- Metric: Numerator: percent improvement in targeted domain
- Data Source: patient survey
- Outcome Improvement Target Estimated Incentive Payment: $129,372
<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Outcome Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$23,904</td>
</tr>
<tr>
<td>3</td>
<td>$55,501</td>
</tr>
<tr>
<td>4</td>
<td>$59,584</td>
</tr>
<tr>
<td>5</td>
<td>$129,372</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $268,361**
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-9.2 ED appropriate utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>085144601.3.32 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>University of Texas Health Science Center at San Antonio</td>
</tr>
<tr>
<td>Performing Provider TPI:</td>
<td>085144601</td>
</tr>
</tbody>
</table>

## Outcome Measure Description:

<table>
<thead>
<tr>
<th>OD-9</th>
<th>Right Care, Right Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-9.2</td>
<td>ED appropriate utilization (Reduce ED visits related to seizures/epilepsy)</td>
</tr>
</tbody>
</table>

Process Milestone for DY2:

P-1 Project Planning – engage stakeholders, identify resources needed, determine timelines

Process Milestone for DY3:

P-2 Establish baseline ED utilization rates

Improvement Targets for DY4 and DY5:

DY4: Decrease ED visits by 25 percent over baseline
DY5: Decrease ED visits by 50 percent over baseline

## Rationale:

Patients with epilepsy who have regular access to epilepsy specialty outpatient care have improved seizure management and increased compliance with epilepsy medication. Noncompliance with epilepsy medication leads to an emergency room visits. With proper medical management, patient compliance with seizure medication will increase, seizure frequency will decrease, and frequency of emergency department visits will decrease.

## Outcome Measure Valuation:

People with epilepsy who do not have access to specialty care generally seek care in an emergency room, at an average cost of $3,000 per visit. Difficulty in accessing needed medications will lead to noncompliance at a cost of about $5,000 per person. For those uninsured and without some type of assistance, epilepsy medications can’t be accessed through Pharma assistance programs ($1,338,525 in such assistance was facilitated by the EFCST in FY 2010 alone) and lost productivity in terms of work-related earnings for people with uncontrolled epilepsy amount to $8,953 per year per household. With seizure control due to appropriate treatment, approximately 60% of could return to work. The cost savings realized by this proposal detailed below is conservative, as it primarily accounts for benefits to those who are uninsured. As mentioned above, approximately 37% have some type of insurance and will be benefitted as well. The table below provides the data used to estimate the conservative value of this proposal in terms of cost savings.

## Cost Savings of This Proposal
<table>
<thead>
<tr>
<th>Total with epilepsy</th>
<th>Number of uninsured with uncontrolled epilepsy (40%)</th>
<th>Direct Cost of uncontrolled epilepsy in uninsured ($9939/person/year)</th>
<th>Indirect of uncontrolled epilepsy in uninsured ($8953/household/year)</th>
<th>Total Cost of uncontrolled epilepsy in uninsured ($18,892)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,348</td>
<td>162</td>
<td>$1,610,118</td>
<td>$1,450,386</td>
<td>$3,060,504</td>
</tr>
</tbody>
</table>
### 85144601.3.32 PASS 2

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>085144601.1.23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD In DY 2</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-1 Project planning – engage stakeholders, identify resources, determine timelines.</td>
<td>P-2 Establish baseline ED utilization rates by patients Improvement Target: Survey patients regarding ED utilization for seizure/epilepsy</td>
<td>IT-9.2 ED appropriate utilization Improvement Target: Reduce ED visits for epilepsy/seizure by 25 pct over baseline in DY2</td>
<td>IT-9.2 ED appropriate utilization Improvement Target: Reduce ED visits for epilepsy/seizure by 50 pct over baseline in DY2</td>
</tr>
<tr>
<td>Data Source: Planning documents</td>
<td>Data Source: Patient Survey</td>
<td>Data Source: Patient Survey/ED records</td>
<td>Data Source: Patient Survey/ED records</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $23,904 | Year 3 Estimated Outcome Amount: $55,501 | Year 4 Estimated Outcome Amount: $59,584 | Year 5 Estimated Outcome Amount: $129,372 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $268,361**
Identifying Outcome Measure and Provider Information:

**Title of Outcome Measure (Improvement Target):** IT-9.1  Decrease in mental health admissions and readmissions to criminal justice settings Such as jails or prisons

**Unique RHP ID:** 085144601.3.33 – PASS 2

**Performing Provider name:** The University of Texas Health Science Center at San Antonio

**TPI:** 085144601

**Outcome Measure Description:**

**Outcome Measure:** number of alcohol offenders who have a new alcohol related driving infraction.

**Process Milestones:** Decrease recidivism for alcohol offenders by 25% to 50%. A 25% to 50% reduction was selected because this would represent a clinically meaningful reduction in alcohol offending. See Table 1 for outcome rates

Milestone 1 is to establish relationship with drug courts. This milestone was chosen because it is allows us access to indigent adults who are in need of alcohol treatment, it provides information used to establish baseline for alcohol offending in our region which is used as comparison to our treatment outcomes. Processes 1, 2, and 3 are utilized to address Milestone 1.

**P-1 Project Planning—engage stakeholders identify current capacity and needed resources.** Milestone 1 is to establish working relationships with hospital emergency departments, social workers and Bexar County Judges and District Attorney's office to develop and pilot our program. During Y2 we will establish working relationships with stakeholders to gain their participation in the development of this program. During Y3, Y4, and Y5 we will sustain involvement by judges and District Attorney's office in pilot programs and to use their input to refine the pilot programs. Process 1 was selected because successful implementation of this treatment program will require partnership with court.

**P-2 Establish baseline rates.** As part of Milestone 1 (establish working relationships with Bexar County Judges and District Attorney's office) we will establish baseline rates for alcohol driving offense recidivism in our local courts and continue to evaluate rates annually during the course of the project. Process 2 was selected because it is necessary to establish baseline rates in order to understand the scope of the health problem.

**P-3 Develop and test data.** As part of Milestone 1 we will analyze current probation practices for alcohol related offenses and conduct analyses of baseline outcome rates. This analyses will be conducted annually, resulting in a written report of our findings. Process 3 was selected because it is necessary to establish current practices of probation courts. This provides some context for comparison to practices and outcomes of this new treatment program.

Milestone 2 is provide a treatment alternative to jail for legally indigent adults convicted of alcohol related driving offenses. This milestone was chosen it represents new access to alcohol treatment for the legally indigent. Process 4 is utilized to address Milestone 2.

**P-4 Conduct Plan Do Study Acts (PDSA) cycles to improve data collection and intervention activities.** Based on our findings from Milestone 1, we will develop a treatment program to reduce alcohol misuse and further alcohol related driving offenses among legally indigent adults convicted of alcohol related driving offenses. This treatment will provide transdermal alcohol monitoring for program participants and utilize this monitoring to individualize treatment plans to reduce alcohol misuse. The goals of this program are to treat the following number of adults by year: 100 in Y2, 150 in Y3, 200 each in Y4 and Y5. This process was selected as a proof of concept program, that is intended to be disseminated to
Milestone 3 is to reduce rates of alcohol recidivism by 25% to 50% of that rate observed for typical probation. This milestone was chosen as an object measure of success of this novel treatment program. Processes 5 and 7 are utilized to address Milestone 3.

P-5 Analyze data from program participants. As part of establishing the effectiveness of Milestone 2, we will compare rates of recidivism from program participants to typical recidivism rates for Bexar county (established in P-2 and P-3).

P-6 Disseminate findings, including lessons learned and best practices, to stakeholders. Test of outcomes from Milestone 3 will be the bases for a report that outlines our success in treating alcohol offenders. Additionally, we will use our experience to develop a manualized treatment plan that drug courts can adopt, which will facilitate their use of transdermal alcohol monitoring to enhance probation success. This process was selected as a means to facilitate adoption of this alcohol program by other drug courts.

P-7 Other activities not described above if any. The treatment providers are interested in developing a training institute to education courts and probation offices on best practices for adopting this novel treatment.

Rationale:
Alternative programs need to be developed to address the issue of intoxicated driving, because the current approach is ineffective and costly. The necessary metrics are clear, and these include number of enrollments in the program, incarceration rates, and reductions in recidivism. Additional metrics will include the number of offenders remaining gainfully employed, reduction in the number of motor vehicle accidents, and those able to continue providing support for their children and/or families.

Outcome Measure Valuation:
Cost of alcohol monitoring and integration with specialized treatment are the two main factors accounting for the valuation of $6,175,000.

1- Cost of alcohol monitoring. An indigent person could not afford the $4,500 cost long term alcohol monitoring used by the therapist to guide treatment.

2.- Cost of therapy. Use of contingency management with motivational interviewing for treatment of substance use disorder is available only at a few academic medical centers (e.g. University of Arkansas for Medical Sciences) and delivered by therapists with specialized training. Treatment cost for these providers is $200/visit. A patient requiring a full 6-months of weekly session could spend almost $5,000 for these services.
<table>
<thead>
<tr>
<th>085144601.3.33</th>
<th>3.IT-9.1</th>
<th>Behavioral Health/Substance Abuse Admission Rate (Decrease in mental health admissions and readmissions to criminal justice settings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS 2</td>
<td>University of Texas Health Science Center at San Antonio</td>
<td>TPI - 085144601.2.6</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

- 085144601 Related Category 1 or 2 Projects: 085144601.2.6

**Starting Point/Baseline:**

- Alcohol is a pervasive problem in Texas, and our state has the 2nd highest number of alcohol-related driving offenses in the nation. Current judicial approaches to curb these offenses are costly; an estimated cost to the state is $5.9 billion dollars.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 - 9/30/2013)</th>
<th>Year 3 (10/1/2013 - 9/30/2014)</th>
<th>Year 4 (10/1/2014 - 9/30/2015)</th>
<th>Year 5 (10/1/2015 - 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 3</strong></td>
<td><strong>Milestone 4</strong></td>
</tr>
<tr>
<td>P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>P-2 Establish baseline rates</td>
<td>IT-9.1 Decrease in mental health admissions to criminal justice setting such as jails or prisons within the measurement period. Goal: &gt;50% of the 200 participants referred to this program will be enrolled as an alternative to incarceration. Data Source: EMR and other performing provider sources.</td>
<td>IT-9.1 Decrease in mental health admissions to criminal justice setting such as jails or prisons within the measurement period. Goal: &gt;50% of the 200 participants referred to this program will be enrolled as an alternative to incarceration. Data Source: EMR and other performing provider sources.</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $23,904

**Year 3 Estimated Outcome Amount:** $55,501

**Year 4 Estimated Outcome Amount:** $129,372

**Year 5 Estimated Outcome Amount:** $129,372

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $338,149
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Outcome Measure (Improvement Target): IT-9.1</td>
<td>Decrease in mental health admissions and readmissions to criminal justice settings</td>
</tr>
<tr>
<td>Unique RHP ID#: 1268443-05.3.1 – PASS 1</td>
<td></td>
</tr>
<tr>
<td>Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
<td></td>
</tr>
<tr>
<td>TPI: 1268443-05</td>
<td></td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

- **Process Milestone for DY 2 is P-1**: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- **Process Milestones for DY 3 will be:**
  - P-2 Establish baseline rates
- **Improvement Target for DY 4 and 5 will be:**
  - IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings.

### Rationale:

DY 2 will be a short year with only 6 months to perform, but important to engage stakeholders, achieve community consensus concerning timelines, location of homes and expectations related to providing these new and innovative services in community settings. We will put our efforts into engagement and development.

DY 3 presents the opportunity to identify and refine data sources and establish the baseline for admission to juvenile justice facilities. We need the juvenile justice system data in order to measure our Improvement Target.

The Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help youth successfully return to family and community. We feel that reductions in removal from home and community is the best measure of success.

### Outcome Measure Valuation:

The project seeks to provide crisis respite to 16 youth in DY 4; and to provide crisis respite to 30 youth in DY 5. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or Juvenile Justice residential treatment facilities. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We assigned a value of $320,101 through DY 5. Complete write-up of project will be available at performing provider site.
<table>
<thead>
<tr>
<th>1268443-05.3.1 PASS 1</th>
<th>3.IT-9.1</th>
<th>Decrease in mental health admissions and readmissions to criminal justice settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
<td>TPI - 1268443-05</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>1268443-05.1.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>No Crisis Respite site or Therapeutic Foster Care site exists in Guadalupe County</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
</tr>
<tr>
<td>P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program Documents</td>
<td>P-2 Establish baseline rates Data Source: Juvenile justice system records, local MH authority and state MH data system records</td>
<td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings below baseline rate TBD. Data Source: Juvenile justice system records, local MH authority and state MH data system records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $28,607</td>
<td>Process Milestone 2 Estimated Incentive Payment: $66,319</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $70,946</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $28,607</td>
<td>Year 3 Estimated Outcome Amount: $66,319</td>
<td>Year 4 Estimated Outcome Amount: $70,946</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $320,101
<table>
<thead>
<tr>
<th>Identifying Outcome Measure and Provider Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Outcome Measure (Improvement Target):</strong> IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</td>
</tr>
<tr>
<td><strong>Unique RHP ID#:</strong> 1268443-05.3.2 – PASS 1</td>
</tr>
<tr>
<td><strong>Performing Provider Name:</strong> Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
</tr>
<tr>
<td><strong>TPI:</strong> 1268443-05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Measure Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone for DY 2</strong> is P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
</tr>
<tr>
<td><strong>Process Milestones for DY 3</strong> will be:</td>
</tr>
<tr>
<td>P-2 Establish baseline rates</td>
</tr>
<tr>
<td>P-3 Develop and test data systems</td>
</tr>
<tr>
<td>P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</td>
</tr>
<tr>
<td><strong>Improvement Target for DY 4 and 5</strong> will be:</td>
</tr>
<tr>
<td>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY 2 will be a short year with only 6 months to perform. We elected to put our efforts into engagement and development.</td>
</tr>
<tr>
<td>DY 3 presents the opportunity to identify and refine data sources. We will also begin our PDSA cycle and continue that Process Milestone into DY’s 4 and 5.</td>
</tr>
<tr>
<td>The Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been in some inpatient or other detoxification program to transition to stable living in the community by providing access to community outpatient services. We will measure readmission.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Measure Valuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The outcome for this project will be a reduction in re-hospitalization which is a good indicator of success for the program and a good indicator of success on a personal basis for those enrolled in the program. Low income individuals cannot now access outpatient care and are left in this cycle of relapse. Extended sobriety and productivity will improve their health outcomes. The valuation calculated for this outcome used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. We established the value at $185,320 through DY 5. Complete write-up of project will be available at performing provider site.</td>
</tr>
<tr>
<td>Project Code</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>1268443-05.3.2</td>
</tr>
<tr>
<td>3.IT-3.8</td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center</td>
</tr>
<tr>
<td>TPI - 1268443-05</td>
</tr>
</tbody>
</table>

| Related Category 1 or 2 Projects: | 1268443-05.1.2 |

| Starting Point/Baseline: | No new outpatient substance abuse treatment site currently exists |

| Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |
| P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. | P- 2 Establish baseline rates | Data Source: Hospital Records | Outcome Improvement Target 1 IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Rate TBD | Data Source: Hospital Records |
| Process Milestone 1 Estimated Incentive Payment: $16,562 | Process Milestone 2 Estimated Incentive Payment: $12,798 | Data Source: Hospital Records | Outcome Improvement Target 1 Estimated Incentive Payment: $41,073 | Outcome Improvement Target 2 Estimated Incentive Payment: $89,291 |
| Process Milestone 3 | P- 3 Develop and test data systems | Outcome Improvement Target 1 Data Source: Hospital Records |
| Process Milestone 2 Estimated Incentive Payment: $12,798 |
| Process Milestone 3 Estimated Incentive Payment: $12,798 |
| Process Milestone 4 | P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. | Data Source: BTCS QM Plan |
| Outcome Improvement Target 2 | IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Rate TBD | Data Source: Hospital Records |

Data Source: Program Documents

Outcome Improvement Target 1 Estimated Incentive Payment: $41,073

Outcome Improvement Target 2 Estimated Incentive Payment: $89,291
| Year 2 Estimated Outcome Amount: $16,562 | Year 3 Estimated Outcome Amount: $38,394 | Year 4 Estimated Outcome Amount: $41,073 | Year 5 Estimated Outcome Amount: $89,291 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $185,320**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate-NQF 1789
Unique RHP ID#: 1268443-05.3.3 – PASS 1
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services
TPI: 1268443-05

Outcome Measure Description:

Process Milestone for DY 2 is P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Process Milestones for DY 3 will be:
P-2 Establish baseline rates
P-3 Develop and test data systems
Improvement Target for DY 4 and 5 will be:
IT-3.1 All cause 30 day readmission rate- NQF 1789 for patients 18 and older

Rationale:

DY 2 We must work with community providers and multiple health care systems to inventory capacity, determine when to initiate program, identify resource needs, complete agreements for data sharing and agreements for site utilization.
DY 3 This population of high frequent visitors to ED is not identified or characterized. We must develop sources of information across multiple health care systems; identify the group and establish a baseline.
The Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been frequent visitors to ED and even though a root cause might be the presence of behavioral health conditions, the admission cause will vary across a variety of physical and mental conditions. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the program. Over the four years of the project we expect to dramatically reduce the number of ED visits for the target population and the associated inpatient admissions. These reductions will occur by improved chronic disease management, linkage to a primary care provider and medical home.

Outcome Measure Valuation:

By targeting and serving 30 high utilizers of ED services in DY 4 and 50 in DY 5 we expect to improve lives and cost and effectiveness of the health care system. We are confident we will impact hospitalization use. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We established a value of $151,627 through DY 5. Complete write-up of project will be available at performing provider site.
<table>
<thead>
<tr>
<th>1268443-05.3.3</th>
<th>3.IT-3.1</th>
<th>All cause 30 day readmission rate- NQF 1789</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PASS 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center</td>
<td></td>
<td>TPI - 1268443-05</td>
</tr>
<tr>
<td>dba/Bluebonnet Trails Community Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
<td>1268443-05.2.1</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline is 0 for DY 2 no such Navigator program currently exists</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program Documents</td>
<td>Process Milestone 2 P- 2 Establish baseline rates Data Source: Hospital Records Process Milestone 2 Estimated Incentive Payment: $15,707</td>
<td>Outcome Improvement Target 1 IT-3.1 All cause 30 day readmission rate- NQF 1789 for patients 18 and older Data Source: Hospital Records Outcome Improvement Target 1 Estimated Incentive Payment: $33,606</td>
</tr>
<tr>
<td>Process Milestone 3 P- 3 Develop and test data systems Data Source: Hospital Records Process Milestone 2 Estimated Incentive Payment: $15,707</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $13,551</td>
<td>Year 3 Estimated Outcome Amount: $31,414</td>
<td>Year 4 Estimated Outcome Amount: $33,606</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $151,627**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</th>
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<tbody>
<tr>
<td>Unique RHP ID#:</td>
<td>1268443-05.3.4 – PASS 2</td>
</tr>
<tr>
<td>Performing Provider Name:</td>
<td>Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services</td>
</tr>
<tr>
<td>TPI:</td>
<td>1268443-05</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

Process Milestone for DY 2 is P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process Milestones for DY 3 will be:
- **P-2 Establish baseline rates**
- **P-3 Develop and test data systems**
- **P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.**

**Improvement Target for DY 4 and 5 will be:**

**IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate.**

### Rationale:

DY 2 will be a short year with only 6 months to perform. We elected to put our efforts into engagement and development.

DY 3 presents the opportunity to identify and refine data sources. We will also begin our PDSA cycle and continue that Process Milestone into DY’s 4 and 5.

This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been hospitalized or experienced a crisis event that could have resulted in a hospitalization to transition to stable living in the community. That transition will be made because of the program interventions that improve functioning and the skills needed for successful community living. When the goal is achieved then program participants will self-manage their recovery and wellness and there should be a reduction in symptoms and a reduction in crisis events. The outcome of this is fewer readmissions to the hospital both for 30 days and in the long term.

### Outcome Measure Valuation:

We expect to provide transitional housing to this group of individuals who have multiple hospital admissions, are frequently homeless and have difficulty with community tenure. We will serve 12 people in DY 4 and 18 people in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). We have assigned a value of $175,559 through DY 5. A description of the method used, titled ‘Valuing Transformation Projects,’ has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115.
Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1268443-05.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline in DY 2 is 0 Baseline to be established in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1**  
| P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.  
| Data Source: Community Meeting Agendas, Minutes and Logs; EHR and Project Documents  
| Process Milestone 1 Estimated Incentive Payment: $15,638 | **Process Milestone 2**  
| P-2 Establish baseline rates  
| Data Source: Hospital Records, Program Records and EHR  
| Process Milestone 2 Estimated Incentive Payment: $12,102 | **Outcome Improvement Target 1**  
| IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.  
| Improvement Target: Rate TBD based on Baseline established in DY 3.  
| Data Source: Hospital Records, Program Records and EHR  
| Outcome Improvement Target 1 Estimated Incentive Payment: $38,979 |
| **Process Milestone 3**  
| P-3 Develop and test data systems  
| Data Source: Hospital Records, Program Records and EHR  
| Process Milestone 3 Estimated Incentive Payment: $12,103 | **Outcome Improvement Target 2**  
| IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.  
| Improvement Target: Rate TBD based on Baseline established in DY 3.  
| Data Source: Hospital Records, Program Records and EHR  
| Outcome Improvement Target 2 Estimated Incentive Payment: $84,634 |
| **Process Milestone 4**  
| P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  
| Data Source: BTCS QM Plan and QM reports.  
| Process Milestone 4 Estimated Incentive Payment: $12,103 | **Outcome Improvement Target 1**  
| IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.  
| Improvement Target: Rate TBD based on Baseline established in DY 3.  
| Data Source: Hospital Records, Program Records and EHR  
<p>| Outcome Improvement Target 1 Estimated Incentive Payment: $38,979 |</p>
<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $15,638</th>
<th>Year 3 Estimated Outcome Amount: $36,308</th>
<th>Year 4 Estimated Outcome Amount: $38,979</th>
<th>Year 5 Estimated Outcome Amount: $84,634</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $175,559**
**Identifying Outcome Measure and Provider Information:**

Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Target: Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.

Unique RHP outcome identification number: 121990904.3.1 – PASS 1

Performing Provider: CAMINO REAL COMMUNITY SERVICES TPI-121990904

**Outcome Measure Description:**

Camino Real Community Services has selected the following process and improvement measures for Category 3:

P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

P-7 (Other activities) Implementation plans: i.e. Facility acquisition, architect drawings, building financing, contractor retention, operational budget including staffing requirements, policy procedure development, etc.

Improvement Target: Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).

Numerator: The number of individuals receiving project crisis stabilization services who were diverted from institutional facilities.

Denominator: Total number of individuals requiring crisis stabilization services.

Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.

Crisis stabilization services will increase by at least 25% by the end of the waiver project.

**Rationale:**

The process milestones and outcome improvement targets selected are those most directly respond to the Transformation Waiver goals and objectives. These milestones and outcome improvement targets directly relate to the provision of community based crisis stabilization services and are milestones and outcomes that are measureable. The outcome improvement targets will be determined in DY 2 for implementation in DY3.

The following evidence supports selection of this project and related outcome targets:


2) The preparatory research supported the conclusion that psychiatric crises requiring acute care with hospitalization account for the largest expenditures in community care. Fenton, W>S., Hoch, JS, Herrell, JM, Mosher, L & Dixon, L., Cost and cost-effectiveness of hospital vs. residential crisis care for patients who have serious mental illness. Arch Gen Psychiatry, 202; 59; 357-364.
3) Sledge, et al concluded that alternative programs had not be “widely implemented” because of the existence of an “incentive structure that discourages their use” and because it is assumed that psychiatric hospitalization is the “most effective method of treatment of those acutely ill psychiatric patients.” P. 1075.

**Outcome Measure Valuation:**

Project valuation takes into consideration:

1) Costs for both state operated Psychiatric Hospitals.
2) Costs of private Psychiatric Hospitals.
3) Local Emergency Room and Hospital costs.
4) Cost of local judicial systems.
5) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.
6) Significant value will be given to a program that can provide services much more responsive to consumer needs with significantly reduced time frames and efficient use of limited resources!
<table>
<thead>
<tr>
<th>TPI-121990904.3.1 PASS 2</th>
<th>3.IT-9.4</th>
<th>Other Outcome Improvement Target: Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.</th>
</tr>
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<tbody>
<tr>
<td>Related Category 1 or 2</td>
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<td>CAMINO REAL COMMUNITY SERVICES TPI-121990904</td>
</tr>
<tr>
<td>Projects:</td>
<td></td>
<td>121990904.1.1</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>Since this service does not exist in the community, baseline will be established Year 4</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
</tr>
<tr>
<td>P-1 Project planning –</td>
<td>P-7 (Other activities)</td>
<td>Improvement Target: Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).</td>
</tr>
<tr>
<td>engage stakeholders,</td>
<td>Implementation plans: i.e. Facility acquisition, architect drawings, building financing, contractor retention, operational budget including staffing requirements, policy procedure development, etc.</td>
<td>Numerator: The number of individuals receiving project crisis stabilization services who were diverted from institutional facilities. Denominator: Total number of individuals requiring crisis stabilization services.</td>
</tr>
<tr>
<td>identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Data Source: Project Plan</td>
<td>Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.</td>
</tr>
<tr>
<td>Data Source: Project Plan</td>
<td></td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>IT-9.4</td>
</tr>
<tr>
<td>Estimated Incentive</td>
<td>Estimated Incentive</td>
<td>Improvement Target: Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).</td>
</tr>
<tr>
<td>Payment: $0</td>
<td>Payment: $173,007</td>
<td>Numerator: The number of individuals receiving project crisis stabilization services who were diverted from institutional facilities. Denominator: Total number of individuals requiring crisis stabilization services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimated Incentive Payment: $277,615</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimated Incentive Payment: $402,341</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$0</td>
<td>Year 3 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong></td>
<td><strong>$852,963</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measures (Improvement Target): | IT-9.2 ED appropriate utilization |
| Unique RHP outcome ID#: | 121990904.3.2 – PASS 2 |
| Performing Provider: | Camino Real Community Services |
| Performing Provider TPI: | 121990904 |

**Outcome Measure Description:**

Camino Real Community Services has selected the following process and improvement measures for Category 3, OD-9 Right Care Right Setting:

**Process Milestones:**

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

DY 3: P-7 (Other activities) Implementation plans: i.e. Facility acquisition, architect drawings, building financing, contractor retention, operational budget including staffing requirements, policy procedure development, etc.

**Outcome Improvement Targets:**

DY 4: IT-9.2 ED appropriate utilization

Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse

DY 5: IT-9.2 ED appropriate utilization

Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse

**Rationale:**

The process milestones and outcome improvement targets selected are those that most directly respond to the Transformation Waiver goals and objectives. According to Practice Guidelines: Core Elements for Responding to Mental Health Crisis (HHS Pub. No. SMA-09-4427;2009) about 6 percent of all hospital emergency department visits reflect mental health emergencies and due to a lack of available alternatives, 79 percent of hospital emergency departments report having to “board” psychiatric patients who are in crisis and in need of inpatient care, sometimes for *eight hours or longer*. As further discussed in the Practice Guidelines, in addition to the human case for improving crisis services, a strong business case can be made and data should be collected accordingly. Current approaches to crisis services needlessly perpetuate reliance on expensive, late-stage interventions (such as hospital emergency departments) and on settings that have inherent risks for harm for people with mental health needs (for instance, jails and juvenile justice facilities).

In 2008, Mental Health or Substance Abuse disorders were the principal reason for 1.8 million inpatient community hospital stays, accounting for 4.5 percent of stays in the U.S. This is according to Brief #117 (Agency for Healthcare Research and Quality, June 2011). It was also noted the MH and SA conditions most frequently treated in community hospitals were mood disorders (depression and bipolar disorder), schizophrenia and other psychotic disorders, alcohol-related disorders and drug-related disorders. These MHSA hospital stays cost $9.7 billion ($7.7 billion for MH; $2.1 billion for SA) nationwide, the MH average length of stay was 8.0 days and the SA average length of stay was 4.8 days with an average cost $5100.
Citations:


**Outcome Measure Valuation:**

Project valuation takes into consideration cost avoidance as related to:

1) Costs for state operated Psychiatric Hospitals.
2) Costs of private Psychiatric Hospitals.
3) Local Emergency Room and Hospital costs.
4) Cost of local judicial systems.
5) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.
<table>
<thead>
<tr>
<th><strong>121990904.3.2</strong></th>
<th><strong>PASS 2</strong></th>
<th><strong>3.IT-9.2</strong></th>
<th><strong>ED appropriate utilization</strong></th>
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<tr>
<td><strong>CAMINO REAL COMMUNITY SERVICES</strong></td>
<td></td>
<td></td>
<td><strong>TPI-121990904</strong></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>121990904.1.2</td>
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<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Since this service does not exist in the community, baseline will be established Year 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>(10/1/2012 – 9/30/2013)</th>
<th>Year</th>
<th>(10/1/2013 – 9/30/2014)</th>
<th>Year</th>
<th>(10/1/2014 – 9/30/2015)</th>
<th>Year</th>
<th>(10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td></td>
<td><strong>Process Milestone 2</strong></td>
<td></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td></td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td></td>
</tr>
<tr>
<td>P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>P-2 Establish Baseline Rates</td>
<td>Data Source: Project Plan</td>
<td>Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse</td>
<td>Goal: TBD</td>
<td>Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.</td>
<td></td>
<td></td>
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<tr>
<td>Data Source: Project Plan</td>
<td>Process Milestone 2 Estimated Incentive Payment: $46,144</td>
<td></td>
<td>Goal: TBD</td>
<td>Data Sources: Claims/encounter and clinical record data (criminal justice system records, local MH authority and state MH data system)</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $74,308</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $107,563</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $0</td>
<td></td>
<td></td>
<td></td>
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</table>

| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $46,144 | Year 4 Estimated Outcome Amount: $74,308 | Year 5 Estimated Outcome Amount: $107,563 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $228,015
### Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-5.1 Improved cost savings: demonstrate cost savings in care delivery.
Unique RHP ID#: 137251808.3.1 – PASS 1
Performing Provider: Center for Health Care Services
TPI: 137251808

### Outcome Measure Description:

**IT-5.1 Improved cost savings: demonstrate cost savings in care delivery.**

- a. Type of analysis to be determined by provider from the following list:
  - Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis
- b. Data source: TBD by provider as appropriate for analysis type
- c. Rationale/Evidence: TBD by provider

Process Milestone(s):

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY2, plans will be developed and in DY3 these new processes will be piloted. This will enable the project to fully achieve the improvement targets of increased appropriate utilization of emergency departments and reduced costs.

### Outcome Improvement Targets for each year:

- **DY4:**
  - IT-5.1 Improved cost savings: demonstrate cost savings in care delivery
  - Improvement Target: TBD

- **DY5:**
  - IT-5.1 Improved cost savings: demonstrate cost savings in care delivery
  - Improvement Target: TBD

### Rationale:

The addition of a Children’s Crisis Respite Center will provide a new, more appropriate care setting for children in crisis and will connect them to more durable, community-based care. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of 30% increase in the utilization of appropriate crisis alternatives in DY4 and a TBD cost avoidance/cost savings factor in DY5.
### Outcome Measure Valuation:

The Category 3 value for this project is $52,595 for DY 2 and $588,512 for all years. The establishment of a Children’s Crisis Respite Center fills an existing gap in the local continuum of behavioral health care for children. The availability of this new resource will ensure children are stabilized, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. This also will be a critical resource and a new option for police departments, schools and child protective services, making it an alternative to more costly and restrictive institutional care. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>137251808.3.1 PASS 1</th>
<th>IT-5.1</th>
<th>Improved cost savings: demonstrate cost savings in care delivery.</th>
</tr>
</thead>
</table>

Center for Health Care Services | TPI - 137251808

Related Category 1 or 2 Projects: 137251808.1.1

New Project Baseline is zero

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1**
P-1, Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: Strategic Plan for Implementation

Process Milestone 1 Estimated Incentive Payment: $52,595

**Process Milestone 2**
P-1, Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: Strategic Plan for Implementation

Process Milestone 2 Estimated Incentive Payment: $121,928

**Outcome Improvement Target 1**
IT-5.1 Improved cost savings: demonstrate cost savings in care delivery.
Improvement Target: TBD
Data Source: Client records
Outcome Improvement Target 1 Estimated Incentive Payment: $130,435

**Outcome Improvement Target 2**
IT-5.1 Improved cost savings: demonstrate cost savings in care delivery.
Improvement Target: TBD
Data Source: Client Records
Outcome Improvement Target 2 Estimated Incentive Payment: $283,554

Year 2 Estimated Outcome Amount: $52,595
Year 3 Estimated Outcome Amount: $121,928
Year 4 Estimated Outcome Amount: $130,435
Year 5 Estimated Outcome Amount: $283,554

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $588,512**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization</th>
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<tbody>
<tr>
<td>Unique RHP ID: 137251808.3.2 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider: Center for Health Care Services</td>
</tr>
<tr>
<td>TPI: 137251808</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**IT-9.2 ED appropriate utilization**

- Reduce all ED Visits
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

### Process Milestone(s):

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY2, plans will be developed and in DY3 these new processes will be piloted. This will enable the project to fully achieve the improvement targets of increased appropriate utilization of emergency departments and reduced costs.

### Outcome Improvement Targets for each year:

- **DY4:**
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD

- **DY5:**
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD

### Rationale:

The addition of a Children’s Crisis Respite Center will provide a new, more appropriate care setting for children in crisis and will connect them to more durable, community-based care. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of **30% increase in the utilization of appropriate crisis alternatives in DY4 and a TBD cost avoidance/cost savings factor in DY5.**
Outcome Measure Valuation:

The Category 3 value for this project is $52,595 for DY 2 and $588,512 for all years. The establishment of a Children’s Crisis Respite Center fills an existing gap in the local continuum of behavioral health care for children. The availability of this new resource will ensure children are stabilized, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. This also will be a critical resource and a new option for police departments, schools and child protective services, making it an alternative to more costly and restrictive institutional care. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data Source: Strategic Plan for Implementation&lt;br&gt;Process Milestone 1 Estimated Incentive Payment: $52,595</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data Source: Strategic Plan for Implementation&lt;br&gt;Process Milestone 2 Estimated Incentive Payment: $121,928</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Improvement Target: TBD&lt;br&gt;Data Source: Client records&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $130,435</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Improvement Target: TBD&lt;br&gt;Data Source: TBD&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $283,554</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $52,595</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $121,928</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $130,435</strong></td>
<td><strong>Year 5 Estimated Outcome Amount: $283,554</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $588,512**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP ID: 137251808.3.3 – PASS 1
Performing Provider: Center for Health Care Services
TPI: 137251808

Outcome Measure Description:

**IT-10.1 Quality of Life-275.276.277 (Standalone measure)**

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
b. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL
c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Process Milestone(s):

- **DY2:** P-1 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  Data Source: PDSA reports
- **DY3:** P-2 - Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  Data Source: PDSA reports

In DY2 the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of enhanced consumer-perceived quality of life.

Outcome Improvement Targets for each year:

- **DY4:**
  - IT-10.1 Quality of Life.
  - Improvement Target: TBA

- **DY5:**
  - IT-10.1 Quality of Life.
  - Improvement Target: TBD
**Rationale:**
The expansion of Adult Outpatient Capacity will fill existing gaps in care in Bexar County, enhancing quality of life and reducing current waiting times for service. However, an efficient and effective service expansion will be supported with the methodical use of PDSA processes, as is planned for DY2-DY3. Expanded services will support achievement of the improvement target of **improved quality of life** (percentage of change TBD in DY4 and DY5).

**Outcome Measure Valuation:**
The Category 3 value for this project is $210,378 for DY 2 and $2,354,043 for all years. The expansion of Adult Outpatient Capacity fills an existing gap in the local continuum of behavioral health care for adults with mental illness. The availability of this increased resource will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates. This work will be made available to University Health System to advise project valuation and outcome measures going forward.
<table>
<thead>
<tr>
<th>137251808.3.3</th>
<th>3.IT-10.1</th>
<th>Quality of Life</th>
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</thead>
<tbody>
<tr>
<td>PASS 1</td>
<td>Center for Health Care Services</td>
<td>TPI - 137251808</td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td>137251808.1.2</td>
<td></td>
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<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>5,835 adults</td>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>IT-10.1 Quality of Life</td>
</tr>
<tr>
<td>Data Source: PDSA reports</td>
<td>Data Source: PDSA reports</td>
<td>Improvement Target: TBA</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $210,378</td>
<td>Process Milestone 2 Estimated Incentive Payment: $487,712</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $521,739</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $210,378</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $487,712</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $521,739</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $2,354,043</td>
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</table>
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate
Unique RHP ID: 137251808.3.4 – PASS 1
Performing Provider: Center for Health Care Services
TPI: 137251808

Outcome Measure Description:

IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate
a  Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.
b  Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission

Process Milestone(s):

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

In DY2, plans will be developed and in DY3 these new processes will be piloted. This will enable the project to fully achieve the improvement target of decreased 30-day re-admission rate for behavioral health or substance abuse.

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate
  - Improvement Target: TBD
- DY5:
  - IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate
  - Improvement Target: TBD

Rationale:

The addition of a Crisis Transitional Residential Center will provide a new, more appropriate care setting for adults in crisis and adults leaving long-term hospitalization in need of step-down care. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of reductions in the Behavioral Health/Substance Abuse 30-day re-admission rate (TBD for DY4 and DY5).
**Outcome Measure Valuation:**

The Category 3 value for this project is $84,151 for DY 2 and $941,618 for all years. The establishment of a Crisis Transitional Residential program for adults will fill an existing gap in the local continuum of behavioral health care. The availability of this new resource will ensure adults in crisis or those leaving long-term hospitalization are connected to care that will support community living and prevent or reduce costly, avoidable re-hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates. This work will be made available to University Health System to advise project valuation and outcome measures going forward.

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<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Strategic Plan for Implementation</td>
<td>P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Strategic Plan for Implementation</td>
<td>IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate. Improvement Target: TBD Data Source: Clinical records.</td>
<td>IT-3.8 Behavioral Health/Substance Abuse 30-day re-admission rate. Improvement Target: TBD Data Source: Clinical records.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $84,151</td>
<td>Process Milestone 2 Estimated Incentive Payment: $195,085</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $208,695</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $453,686</td>
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<td>Year 2 Estimated Outcome Amount: $84,151</td>
<td>Year 3 Estimated Outcome Amount: $195,085</td>
<td>Year 4 Estimated Outcome Amount: $208,695</td>
<td>Year 5 Estimated Outcome Amount: $453,686</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $941,618**
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-10.1 Quality of Life</th>
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</thead>
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<tr>
<td>Unique RHP ID:</td>
<td>137251808.3.5 – PASS 1</td>
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<tr>
<td>Performing Provider:</td>
<td>Center for Health Care Services</td>
</tr>
<tr>
<td>TPI:</td>
<td>137251808</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**IT-10.1 Quality of Life**

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL

c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

### Process Milestone(s):

- **DY2:**
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

- **DY3:**
  - P-4 Project planning – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

In DY2, the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of enhanced consumer-perceived quality of life.

### Outcome Improvement Targets for each year:

- **DY4:**
  - IT-10.1 Quality of Life
  - Improvement Target: TBD

- **DY5:**
  - IT-10.1 Quality of Life
  - Improvement Target: TBD
### Rationale:
The expansion of Children’s Mental Health Services will fill existing gaps in care in Bexar County, enhancing quality of life and creating a durable system of care for children with behavioral health needs. However, an efficient and effective service expansion will be supported with the methodical use of PDSA processes, as is planned for DY2-DY3. Expanded services will support achievement of the improvement target of improved quality of life (percentage of change TBD in DY4 and DY5).

### Outcome Measure Valuation:
The Category 3 value for this project is $92,567 for DY 2 and $1,035,779 for all years. The expansion of Children’s Mental Health Services fills an existing gap in the local continuum of behavioral health care for children. The availability of this increased resource will ensure children are stabilized, connected to systems of care that will support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>Center for Health Care Services</th>
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<tbody>
<tr>
<td>137251808.3.5 PASS 1</td>
<td>TPI - 137251808</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137251808.1.4</td>
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<td>Starting Point/Baseline:</td>
<td>454 children per year</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <a href="#">Data Source: PDSA reports</a></td>
<td><strong>Process Milestone 2</strong> P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <a href="#">Data Source: PDSA reports</a></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $92,567</td>
<td>Process Milestone 2 Estimated Incentive Payment: $214,593</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $92,567</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $214,593</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,035,779
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
Unique RHP ID: 137251808.3.6 – PASS 1
Performing Provider: Center for Health Care Services
TPI: 137251808

Outcome Measure Description:

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

   a Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period.

   b Denominator: The number of individuals receiving project intervention(s)

   c Data Sources: Claims/encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records

   d Rationale/Evidence: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivism criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

Process Milestone(s):

   • DY2:
     o P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

   • DY3:
     o P-4 Project planning – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

In DY2 the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of decrease in mental health admissions and re-admissions to criminal justice settings.

Outcome Improvement Targets for each year:

   • DY4:
     o IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings
     o Improvement Target: TBD

   • DY5:
     o IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings
     o Improvement Target: TBD
Rationale:

The expansion of Adult Outpatient Capacity will fill existing gaps in care in Bexar County. However, an efficient and effective service expansion will be supported with the methodical use of PDSA processes, as is planned for DY2-DY3. Expanded services will support achievement of the improvement target of decrease in mental health admissions and re-admissions to criminal justice settings (percentage of change TBD in DY4 and DY5).

Outcome Measure Valuation:

The Category 3 value for this project is $180,924 for DY 2 and $2,024,476 for all years. The expansion of IOPC fills an existing gap in the local continuum of behavioral health care for adults with mental illness. The availability of this increased resource will support community living and prevent or reduce incarceration and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates. This work will be made available to University Health System to advise project valuation and outcome measures going forward.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>137251808.3.6 PASS 1</th>
<th>3.IT-9.1</th>
<th>Decrease in mental health admissions and readmissions to criminal justice settings</th>
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<tr>
<td>Center for Health Care Services</td>
<td>137251808.2.1</td>
<td>TPI - 137251808</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>244 adults</td>
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<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1</td>
<td>Process Milestone 2</td>
<td>Outcome Improvement Target 1</td>
</tr>
<tr>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings. Improvement Target: TBD</td>
</tr>
<tr>
<td>Data Source: PDSA reports</td>
<td>Data Source: PDSA reports</td>
<td>Data Source: Client records</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $180,924</td>
<td>Process Milestone 2 Estimated Incentive Payment: $419,433</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $448,695</td>
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<td></td>
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<td>Year 2 Estimated Outcome Amount: $180,924</td>
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<tr>
<td></td>
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<td>Year 4 Estimated Outcome Amount: $448,695</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,024,476**
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization
Unique RHP ID: 137251808.3.7 – PASS 1
Performing Provider: Center for Health Care Services
TPI: 137251808

Outcome Measure Description:
IT-9.2 ED appropriate utilization
- Reduce all ED Visits
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

Process Milestone(s):
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

In DY2, plans will be developed and in DY3 these new processes will be piloted. This will enable the project to fully achieve the improvement target of decreased emergency department utilization.

Outcome Improvement Targets for each year:
- DY4:
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD
- DY5:
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD

Rationale:
The addition of integrated behavioral and primary health care will provide new, improved care for high need, homeless adults with substance abuse disorders, mental illness and, in some cases, co-occurring disorders. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of increases in the appropriate utilization of emergency departments (TBD for DY4 and DY 5).
Outcome Measure Valuation:
The Category 3 value for this project is $80,996 for DY 2 and $906,307 for all years. The integration of primary and behavioral health care will improve available resources for the target population of high need, homeless adults, most of whom will have chronic behavioral health and physical health conditions. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>137251808.3.7</th>
<th>3.IT-9.2</th>
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<td>PASS 1</td>
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<td>TPI - 137251808</td>
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<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2</strong> P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Outcome Improvement Target 1</strong> IT-9.2 ED appropriate utilization</td>
<td><strong>Outcome Improvement Target 2</strong> IT-9.2 ED appropriate utilization</td>
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<td>Data Source: Strategic Plan for Implementation</td>
<td>Data Source: Strategic Plan for Implementation</td>
<td>Improvement Target: TBD Data Source: Client records</td>
<td>Improvement Target: TBD Data Source: Client records</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $80,996</td>
<td>Process Milestone 2 Estimated Incentive Payment: $187,769</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $200,869</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $436,673</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $80,996</td>
<td>Year 3 Estimated Outcome Amount: $187,769</td>
<td>Year 4 Estimated Outcome Amount: $200,869</td>
<td>Year 5 Estimated Outcome Amount: $436,673</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $906,307**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-9.2 ED appropriate utilization |
| Unique RHP ID:          | 137251808.3.8 – PASS 1 |
| Performing Provider:    | Center for Health Care Services |
| TPI:                   | 137251808 |

### Outcome Measure Description:

**IT-9.2 ED appropriate utilization**

- Reduce all ED Visits
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions:
  - Behavioral Health/Substance Abuse

**Process Milestone(s):**

- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

In DY2, plans will be developed and in DY3 these new processes will be piloted. This will enable the project to fully achieve the improvement target of decreased emergency department utilization.

### Outcome Improvement Targets for each year:

- **DY4:**
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD
- **DY5:**
  - IT-9.2 appropriate utilization
  - Improvement Target: TBD

### Rationale:

The addition of integrated behavioral and primary health care will provide new, improved care for adults with substance abuse disorders and, in some cases, HIV. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of increases in the appropriate utilization of emergency departments (TBD for DY4 and DY 5).
**Outcome Measure Valuation:**

The Category 3 value for this project is $88,359 for DY 2 and $988,698 for all years. The integration of primary and behavioral health care will improve available resources for substance abusing adults and adults with a co-occurring substance abuse issue and HIV. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>137251808.3.8 PASS 1</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization</th>
</tr>
</thead>
<tbody>
<tr>
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<td><strong>TPI - 137251808</strong></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>New Project, baseline is zero</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data Source: Strategic Plan for Implementation</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data Source: Strategic Plan for Implementation</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Improvement Target: TBD&lt;br&gt;Data Source: Client records</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $88,359</td>
<td>Process Milestone 2 Estimated Incentive Payment: $204,839</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $219,130</td>
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<td><strong>Year 2 Estimated Outcome Amount: $88,359</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $204,839</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $219,130</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $988,698**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life |
| Unique RHP Identification Number: 137251808.3.9 – PASS 2 |
| Provider Name: Center for Health Care Services |
| TPI: 137251808 |

**Outcome Measure Description:**

**IT-10.1 Quality of Life**

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population or their caregivers.
b. Data source: AQoL, SF-36, 20 or 12, PedsQL
c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by surveying the patient or their caregivers in the case of children or non-communicative adults. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

**Process Milestone(s):**

- **DY2:**
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- **DY3:**
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

In DY2, the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of enhanced consumer-perceived quality of life.

**Outcome Improvement Targets for each year:**

- **DY4:**
  - IT-10.1 Quality of Life
  - Improvement Target: TBD

- **DY5:**
  - IT-10.1 Quality of Life
  - Improvement Target: TBD

**Rationale:**

The expansion of integrated, specialized care for children and adults who are dually diagnosed with mental illness and intellectual developmental disabilities (IDD) will fill existing gaps in care in Bexar County, will enhance quality of life and will create a durable system of care for children and adults with special, often unmet needs. An efficient and effective service expansion
will be supported with the methodical use of PDSA processes, as is planned for DY2-DY3. Expanded services will support achievement of the improvement target of improved quality of life (percentage of change TBD in DY4 and DY5).

**Outcome Measure Valuation:**

The Category 3 value for this project is $87,047 for DY 2 and $973,618 for all years. The proposed service expansion fills an existing gap in the local continuum of behavioral health care for dually diagnosed children and adults. The availability of this enhanced resource will ensure the target population is stabilized and connected to durable systems of care that support community living and prevent or reduce costly, avoidable hospitalization, lengthy stays in institutions, further crises and the inappropriate use of emergency departments. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
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<thead>
<tr>
<th>137251808.3.9</th>
<th>3.IT-10.1</th>
<th>Quality of Life</th>
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<tbody>
<tr>
<td>PASS 2</td>
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<td>TPI - 137251808</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137251808.1.5</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>454 children per year</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-4, Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-10.1 Quality of Life</td>
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<tr>
<td>Data Source: PDSA reports</td>
<td>Data Source: PDSA reports</td>
<td>Improvement Target: TBA</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $87,047</td>
<td>Process Milestone 2 Estimated Incentive Payment: $201,275</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $216,089</td>
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<td><strong>Year 2 Estimated Outcome Amount: $87,047</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $201,275</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $216,089</strong></td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $973,618**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of life/Functional status
Unique RHP Outcome Identification Number: 137251808.3.10 – PASS 2
Provider Name: Center for Health Care Services
TPI: 137251808

Outcome Measure Description:

IT-10.1 Quality of Life

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population or their caregivers.
b. Data source: AQoL, SF-36, 20 or 12, PedsQL
c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by surveying the patient or their caregivers in the case of children or non-communicative adults. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Process Milestone(s):

- DY2:
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- DY3:
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

In DY2, the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of enhanced consumer-perceived quality of life.

Outcome Improvement Targets for each year:

- DY4:
  - IT-10.1 Quality of Life
  - Improvement Target: TBD

- DY5:
  - IT-10.1 Quality of Life
  - Improvement Target: TBD
**Rationale:**
The addition of a multi-entity continuum of integrated care will yield new, improved services for high-utilizing homeless adults with substance abuse disorders, mental illness and, in some cases, co-occurring disorders, and will improve outcomes and drive down costs. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of increases in the appropriate utilization of emergency departments (TBD for DY4 and DY 5).

**Outcome Measure Valuation:**
The Category 3 value for this project is $84,347 for DY 2 and $963,163 for all years. An integrated continuum and a shared treatment plan will improve treatment of the target population. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

**Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.**

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
### 3.IT-10.1 Quality of Life / Functional Status

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Center for Health Care Services</th>
<th>TPI - 137251808</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>137251808.2.4</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>IT-10.1 Quality of Life</td>
<td>IT-10.1 Quality of Life</td>
</tr>
<tr>
<td>Data Source: PDSA reports</td>
<td>Data Source: PDSA reports</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $84,347</td>
<td>Process Milestone 3 Estimated Incentive Payment: $199,571</td>
<td>Data Source: validated assessment tools</td>
<td>Data Source: validated assessment tools</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $84,347</td>
<td>Year 3 Estimated Outcome Amount: $199,571</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $214,216</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $465,029</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $963,163
### Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life  
Unique RHP Identification Number: 137251808.3.11 – PASS 2  
Provider Name: Center for Health Care Services  
TPI: 137251808

### Outcome Measure Description:

**IT-10.1 Quality of Life**

- Demonstrate improvement in quality of life (QOL) scores, as measured by evidenced based and validated assessment tool, for the target based population.
- Data source: SF-36
- Rationale/Evidence: In a similar activity -- Project HOMES -- CHCS has already demonstrated statistically significant quality of life improvements using the SF-36

Process Milestone(s):

- **DY3:**  
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

In DY2, the first PDSA cycle will occur and quality-enhancing improvements to processes and methods will be identified. In DY3 these new processes will be implemented and the PDSA cycle will be repeated to verify achievement of the desired impact. This will enable the project to fully achieve the improvement targets of enhanced consumer-perceived quality of life.

### Outcome Improvement Targets for each year:

- **DY4:**  
  - IT-10.1 Quality of Life  
  - Improvement Target: TBD

- **DY5:**  
  - IT-10.1 Quality of Life  
  - Improvement Target: TBD

1 Center For Health Care Services. (2012). SAMHSA Project HOMES Bi-Annual Report. San Antonio, Texas. (Stringfellow)

### Rationale:

The IHWWP will help to meet an existing need for a comprehensive, safe, structured, integrated care management program for high-need, homeless females in Bexar County. Because the target population often has a complex combination of physical and behavioral health care needs combined with concomitant issues of substance abuse, traumatic injury, cognitive challenges and a lack of daily living skills and natural supports, they are frequent users of Emergency Departments (ED) and other public health services. This project will expand available treatment options (SS, WSM, and Matrix Psycho social EBPs) for males and females and will establish a parallel, 24 bed dormitory (IHWWP) for females, which will improve outcomes and drive down
costs. However, maximizing this new resource will require strategic planning and methodical implementation, as is planned for DY2-DY3. The availability of this intervention will trigger achievement of the improvement targets of increases in the appropriate utilization of emergency departments (TBD for DY4 and DY 5).

**Outcome Measure Valuation:**

The Category 3 value for this project is $52,991 for DY 2 and $582,297 for all years. As part of the proposed project, CHCS will quantify cost savings attributable to the approach. CHCS has a significant amount of existing infrastructure from which this project can be launched and only site preparation is required; thereby driving down the required investment and increasing the cost effectiveness of the approach. The cost formulas lowered the scoring for projects with existing investments of infrastructure and resources and increased the scoring for projects requiring the greatest investment. However, CHCS has contracted with a medical economist to conduct studies of the project and their data has determined values that exceed the DSRIP estimates.

*Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.*

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
<table>
<thead>
<tr>
<th>137251808.3.11 PASS 2</th>
<th>3.IT-10.1</th>
<th>Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Health Care Services</td>
<td>137251808.2.5</td>
<td>TPI - 137251808</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Process Milestone 2 P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Outcome Improvement Target 1 IT-10.1 Quality of Life Improvement Target: TBD Data Source: SF-36 documentation</td>
<td>Outcome Improvement Target 2 IT-10.1 Quality of Life Improvement Target: TBD Data Source: SF-36 documentation</td>
</tr>
<tr>
<td>Data Source: Project Documents</td>
<td>Data Source: Policies and Procedures</td>
<td>Process Milestone 2 Estimated Incentive Payment: $120,136</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $129,001</td>
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<td>Year 2 Estimated Outcome Amount: $52,991</td>
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<td>Year 3 Estimated Outcome Amount: $120,136</td>
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<td>Year 4 Estimated Outcome Amount: $129,001</td>
<td>Year 5 Estimated Outcome Amount: $280,169</td>
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<tr>
<td></td>
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<td></td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $582,297</td>
</tr>
</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Mobile Crisis Outreach Teams

Unique RHP Outcome Identification number: 133340307.3.1 – PASS 1

Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

TPI: 133340307

**Outcome Measure Description:**

Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales.

Process Milestones:
Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale

DY4 IT10.2 15% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale

DY5 IT10.2 20% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale

**Rationale:**

Rationale for Improvement Targets:
Mobile Crisis Outreach Team service impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help
identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

Outcome measures are based on the number of individuals that have begun treatment in the Trauma Informed Care program and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

The Activities of Daily Living will be utilized to measure how a person is functioning at the present time, and to identify improvement over time. By measuring the Activities of Daily Living of an individual before and after treatment, the impact of the treatment on an individual’s capability to function appropriately in society, thus increasing the potential for employment and for better health, will be captured to demonstrate the success of the project. Outcome measures were kept modest due to the interventions requiring a change in the individual’s lifestyle which will take time to implement or where the individual may be resistant to change.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

### Outcome Measure Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on 190 consumers over the life of the project resulting in a valuation overall of $15,642 per individual served.
### 3.IT-10.2 Activities of Daily Living/Mobile Crisis Outreach Teams

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tr>
<td>Outcome Improvement Target 1:</td>
<td>Outcome Improvement Target 2:</td>
<td>Outcome Improvement Target 3:</td>
<td></td>
</tr>
<tr>
<td>IT-10.2: Activities of Daily</td>
<td>IT-10.2: Activities of Daily</td>
<td>IT-10.2: Activities of Daily</td>
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</tr>
<tr>
<td>Living</td>
<td>Living</td>
<td>Living</td>
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</tr>
<tr>
<td>Improvement Target: 10% have</td>
<td>Improvement Target: 15% have</td>
<td>Improvement Target: 20% have</td>
<td></td>
</tr>
<tr>
<td>improvement on subsequent</td>
<td>improvement on subsequent</td>
<td>improvement on subsequent</td>
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</tr>
<tr>
<td>Activities of Daily</td>
<td>Activities of Daily</td>
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<td>Living Data Source: Hill Country</td>
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<td>MHDD records/EHR</td>
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<td>MHDD records/EHR</td>
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<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
<td>Outcome Improvement Target 3</td>
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<tr>
<td>Estimated Incentive Payment:</td>
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<tr>
<td>$72,574</td>
<td>$116,455</td>
<td>$168,776</td>
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</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $72,574  
**Year 3 Estimated Outcome Amount:** $72,574  
**Year 4 Estimated Outcome Amount:** $116,455  
**Year 5 Estimated Outcome Amount:** $168,776

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $357,805
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)</th>
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<tr>
<td>Unique RHP outcome Identification number:</td>
<td>133340307.3.2 – PASS 1</td>
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<tr>
<td>Performing Provider:</td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
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<tr>
<td>TPI:</td>
<td>133340307</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

Outcome Measure Description:

IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians: PHQ-A/BDI-PC for Adolescents (12-18 years old)

The number of PHQ-A/BDI-PC performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population ages 12 to 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates

### Process Milestones:

Not applicable

### Outcome Improvement Targets for each year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
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</thead>
<tbody>
<tr>
<td>DY2</td>
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</tr>
<tr>
<td>DY3</td>
<td>IT12.5 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
</tr>
<tr>
<td>DY4</td>
<td>IT12.5 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
</tr>
<tr>
<td>DY5</td>
<td>IT12.5 5% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
</tr>
</tbody>
</table>

### Rationale:

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.
Outcome Measure Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 4,000 consumers over the life of the project (500 during DY3; 1,500 during DY4; and 2,000 during DY5) resulting in a valuation per patient of $1,486.04.
<table>
<thead>
<tr>
<th>133340307.3.2</th>
<th>3.IT-12.5</th>
<th>Other USPSTF endorsed screening (PHQ-A and BDI-PC)</th>
</tr>
</thead>
<tbody>
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<td>PASS 1</td>
<td></td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
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<td>TPI - 133340307</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>Service not currently offered</td>
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<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tbody>
<tr>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
<td>Outcome Improvement Target 3</td>
<td></td>
</tr>
<tr>
<td>IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC)</td>
<td>IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC)</td>
<td>IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC)</td>
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</tr>
<tr>
<td>Improvement Target: 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
<td>Improvement Target: 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
<td>Improvement Target: 5% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment</td>
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<tr>
<td>Data Source: Hill Country MHDD records/EHR/Primary Physician Reports</td>
<td>Data Source: Hill Country MHDD records/EHR/Primary Physician Reports</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $30,000</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $45,000</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $60,000</td>
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</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $30,000  
Year 3 Estimated Outcome Amount: $30,000  
Year 4 Estimated Outcome Amount: $45,000  
Year 5 Estimated Outcome Amount: $60,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $135,000
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): | IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9) |
| Unique RHP outcome Identification number: | 133340307.3.3 – PASS 1 |
| Performing Provider: | Hill Country Community MHMR Center (dba Hill Country MHDD Centers) |
| TPI: | 133340307 |

**Outcome Measure Description:**

Outcome Measure Description:

IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians: PHQ-9 for Major Depression in Adults

The number of PHQ-9 performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates

Process Milestones:
Not applicable

Outcome Improvement Targets for each year:

- **DY2** – Not Applicable
- **DY3** IT12.5 2% of population of 18 have received PHQ-9 assessment
- **DY4** IT12.5 2% of population of 18 have received PHQ-9 assessment
- **DY5** IT12.5 2% of population of 18 have received PHQ-9 assessment

**Rationale:**

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.
<table>
<thead>
<tr>
<th>Outcome Measure Valuation:</th>
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<tbody>
<tr>
<td>Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 4,000 consumers over the life of the project (500 during DY3; 1,500 during DY4; and 2,000 during DY5) resulting in a valuation per patient of $1,486.04</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9)</td>
</tr>
<tr>
<td>Improvement Target: 2% of population of 18 have received PHQ-9 assessment</td>
</tr>
<tr>
<td>Data Source: Hill Country MHDD records/HER/Primary Physician Reports</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $85,147</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $85,147  
Year 3 Estimated Outcome Amount: $85,147  
Year 4 Estimated Outcome Amount: $142,910  
Year 5 Estimated Outcome Amount: $217,551

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $445,608**
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome Identification number:</td>
<td>133340307.3.4 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI:</td>
<td>133340307</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

- IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians CAGE and AUDIT for Adult Substance Use Disorder

The number of CAGE/AUDIT performed by Primary Care Physicians on patients individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates

**Process Milestones:**
- Not applicable

**Outcome Improvement Targets for each year:**
- DY2 – Not Applicable
- DY3 IT12.5 2% of population 12 to 18 years old have received CAGE/AUDIT assessment
- DY4 IT12.5 3% of population 12 to 18 years old have received CAGE/AUDIT assessment
- DY5 IT12.5 5% of population 12 to 18 years old have received CAGE/AUDIT assessment

**Rationale:**

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.
### Outcome Measure Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 4,000 consumers over the life of the project (500 during DY3; 1,500 during DY4; and 2,000 during DY5) resulting in a valuation per patient of $1,486.04.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133340307.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Service not currently available</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td><strong>Outcome Improvement Target 3</strong></td>
<td></td>
</tr>
<tr>
<td>IT-12.5: Other USPSTF endorsed screening (CAGE and AUDIT)</td>
<td>IT-12.5: Other USPSTF endorsed screening (CAGE and AUDIT)</td>
<td>IT-12.5: Other USPSTF endorsed screening (CAGE and AUDIT)</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: 2% of population of 18 have received CAGE/AUDIT assessment</td>
<td>Improvement Target: 3% of population of 18 have received CAGE/AUDIT assessment</td>
<td>Improvement Target: 5% of population of 18 have received CAGE/AUDIT assessment</td>
<td></td>
</tr>
<tr>
<td>Data Source: Hill Country MHDD records/HER/Primary Physician Reports</td>
<td>Data Source: Hill Country MHDD records/HER/Primary Physician Reports</td>
<td>Data Source: Hill Country MHDD records/HER/Primary Physician Reports</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $30,000</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $45,000</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $60,000</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: | Year 3 Estimated Outcome Amount: $30,000 | Year 4 Estimated Outcome Amount: $45,000 | Year 5 Estimated Outcome Amount: $60,000 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $135,000
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT 10.2 Activities of Daily Living/Co-occurring Psychiatric and Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome Identification number:</td>
<td>133340307.3.5 – PASS 1</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI:</td>
<td>133340307</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**Outcome Measure Description:**

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales.

**Process Milestones:**

Not applicable

**Outcome Improvement Targets for each year:**

- **DY2 – Not Applicable**
- **DY3** IT10.2 10% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale
- **DY4** IT10.2 15% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale
- **DY5** IT10.2 20% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale

### Rationale:

Co-occurring Psychiatric and Substance Use Disorder impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.


For the targeted population, individuals with Co-occurring Psychiatric and Substance Use...
Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that have begun treatment in the Co-occurring Psychiatric and Substance Use Disorder program and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 234 consumers over the life of the project resulting in a overall value of $19,054 per individual served.
<table>
<thead>
<tr>
<th>133340307.3.5 PASS 1</th>
<th>3.IT-10.2</th>
<th>Activities of Daily Living Co-occurring Psychiatric and Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
<td>TPI - 133340307.2.3</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
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<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Outcome Improvement Target 1**  
IT-10.2: Activities of Daily Living Co-occurring Psychiatric and Substance Use Disorder  
Improvement Target: 10% have improvement on subsequent Activities of Daily Living  
Data Source: Hill Country MHDD records/EHR  
Outcome Improvement Target 1 Estimated Incentive Payment: $108,860 | **Outcome Improvement Target 2**  
IT-10.2: Activities of Daily Living Co-occurring Psychiatric and Substance Use Disorder  
Improvement Target: 15% have improvement on subsequent Activities of Daily Living  
Data Source: Hill Country MHDD records/EHR  
Outcome Improvement Target 2 Estimated Incentive Payment: $174,683 | **Outcome Improvement Target 3**  
IT-10.2: Activities of Daily Living Co-occurring Psychiatric and Substance Use Disorder  
Improvement Target: 20% have improvement on subsequent Activities of Daily Living  
Data Source: Hill Country MHDD records/EHR  
Outcome Improvement Target 3 Estimated Incentive Payment: $253,163 |

Year 2 Estimated Outcome Amount: $108,860  
Year 3 Estimated Outcome Amount: $108,860  
Year 4 Estimated Outcome Amount: $174,683  
Year 5 Estimated Outcome Amount: $253,163

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $536,706
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Trauma Informed Care
Unique RHP outcome Identification number: 133340307.3.6 – PASS 1
Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
TPI: 133340307

Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales.

Process Milestones:
Not applicable

Outcome Improvement Targets for each year:
DY2 – Not Applicable
DY3 IT10.2 10% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale
DY4 IT10.2 15% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale
DY5 IT10.2 20% of individuals receiving services through the project show improvement on subsequent Activities of Daily Living scale

Rationale:

Trauma impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving.
family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

Outcome measures are based on the number of individuals that have begun treatment in the Trauma Informed Care program and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on 200 consumers over the life of the project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133340307.2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Service not currently available</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 10% have improvement on subsequent Activities of Daily Living&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $116,118</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 15% have improvement on subsequent Activities of Daily Living&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $186,328</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Outcome Improvement Target 3</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 20% have improvement on subsequent Activities of Daily Living&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 3 Estimated Incentive Payment: $270,041</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td><strong>Outcome Improvement Target 3</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 20% have improvement on subsequent Activities of Daily Living&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 3 Estimated Incentive Payment: $270,041</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $116,118</td>
</tr>
<tr>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $186,328</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $270,041</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $572,487**
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living / Whole Health Peer Support
Unique RHP outcome Identification number: 133340307.3.7 – PASS 2
Provider Name: Hill Country Community MFMR Center (dba Hill Country MHDD Centers)
TPI: 133340307

Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health

Process Milestones:
Not applicable

Outcome Improvement Targets for each year:
DY2 – Not Applicable
DY3 IT10.2 10% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
DY4 IT10.2 15% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
DY5 IT10.2 20% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Rationale:

Whole Health Peer Support services impact an individual’s mental and physical health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and
Managing Money.

Outcome measures are based on the number of individuals that have begun treatment in the Whole Health Peer Support program and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Whole Health Peer Support services who show improvement on the DLA-20 compared to the total number receiving Whole Health Peer Support services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program’s value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be individual DLA20 assessment as individuals enter program</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
<td>Outcome Improvement Target 3</td>
<td></td>
</tr>
<tr>
<td>IT-10.2: Activities of Daily</td>
<td>IT-10.2: Activities of Daily</td>
<td>IT-10.2: Activities of Daily</td>
<td></td>
</tr>
<tr>
<td>Living Improvement Target: 10% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20)</td>
<td>Improvement Target: 15% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20)</td>
<td>Improvement Target: 20% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20)</td>
<td></td>
</tr>
<tr>
<td>Data Source: Hill Country MHDD records/EHR</td>
<td>Data Source: Hill Country MHDD records/EHR</td>
<td>Data Source: Hill Country MHDD records/EHR</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $33,804</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $55,392</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $82,215</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $33,804</td>
<td>Year 4 Estimated Outcome Amount: $55,392</td>
<td>Year 5 Estimated Outcome Amount: $82,215</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $171,411**
## Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-10.2 Activities of Daily Living/Veteran Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome Identification number:</td>
<td>133340307.3-8 – PASS 2</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>Hill Country Community MFMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI:</td>
<td>133340307</td>
</tr>
</tbody>
</table>

## Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health.

Process Milestones:
Not applicable

Outcome Improvement Targets for each year:
- **DY2** – Not applicable
- **DY3** IT10.2 10% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- **DY4** IT10.2 15% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- **DY5** IT10.2 20% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

## Rationale:

Veteran Mental Health services impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.


For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and
Managing Money.

Outcome measures are based on the number of individuals that are referred from Veteran Peer Support to community based wrap around services and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Veteran Mental Health services who show improvement on the DLA-20 compared to the total number receiving Veteran Mental Health services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 180 consumers over the life of the project.
<table>
<thead>
<tr>
<th>133340307.3.8 PASS 2</th>
<th>3.IT-10.2</th>
<th>Activities of Daily Living/Veteran Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</td>
<td>133340307</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
<td>133340307.2.6</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be individual DLA20 assessments as individuals enter program</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td><strong>Outcome Improvement Target 3</strong></td>
<td></td>
</tr>
<tr>
<td>IT-10.2: Activities of Daily Living Improvement Target: 10% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</td>
<td>IT-10.2: Activities of Daily Living Improvement Target: 15% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</td>
<td>IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $50,904</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $83,409</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $123,798</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $50,904 | Year 4 Estimated Outcome Amount: $83,409 | Year 5 Estimated Outcome Amount: $123,798 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $258,111
### Identifying Outcome Measure and Provider Information:

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-10.2 Activities of Daily Living/Mental Health Courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome Identification number:</td>
<td>133340307.3.9 – PASS 2</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>Hill Country Community MFMR Center (dba Hill Country MHDD Centers)</td>
</tr>
<tr>
<td>TPI:</td>
<td>133340307</td>
</tr>
</tbody>
</table>

### Outcome Measure Description:

**IT-10.2 Activities of Daily Living** – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health.

**Process Milestones:**

Not applicable

**Outcome Improvement Targets for each year:**

- **DY2 – Not Applicable**
- **DY3 IT10.2** 10% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- **DY4 IT10.2** 15% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- **DY5 IT10.2** 20% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

### Rationale:

Mental Health Court services impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.


For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and
Managing Money.

Outcome measures are based on the number of individuals participating in Mental Health Court services and were kept modest due to the intervention requiring a change in the individual’s lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Mental Health Court services who show improvement on the DLA-20 compared to the total number receiving Mental Health Court services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcomes Measure Valuation:

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The valuation on this project is based on 120 consumers over the life of the project.
| Related Category 1 or 2 Projects: | 133340307.2.7 |
| Starting Point/Baseline: | Baseline will be individual DLA20 assessments as individuals enter program |

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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 10% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20)&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $33,371</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 15% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20)&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $51,346</td>
<td><strong>Outcome Improvement Target 3</strong>&lt;br&gt;IT-10.2: Activities of Daily Living&lt;br&gt;Improvement Target: 20% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20)&lt;br&gt;Data Source: Hill Country MHDD records/EHR&lt;br&gt;Outcome Improvement Target 3 Estimated Incentive Payment: $69,225</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $33,371</td>
<td>Year 4 Estimated Outcome Amount: $51,346</td>
<td>Year 5 Estimated Outcome Amount: $69,225</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $153,942
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-7.1 Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number:</td>
<td>091308902.3.1 (PASS 1)</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>TPI:</td>
<td>082426001</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

**Improvement Target** IT-7.1 Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth

**Improvement Target: IT (Non-Stand Alone)**

Measure will track increase in the number of unduplicated encounters for children ages 6-9 over established baseline of children ages 6-9 enrolled in participating programs

| DY 3 | NA |
|      |    |
| DY 4 | X% Increase over baseline |
| DY 5 | X% Increase over baseline |

**Related Process Milestone**-

DY 3 Establish baseline % of participating 3rd grade students with a dental sealant on at least one permanent first molar

**Rationale:**

*Outcome improvement targets will be determined in DY3 for implementation in DY4-5*

**IT-7.1 Dental Sealants:** Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth relative to baseline data

a. **Numerator:** Number of participating 3rd grade students with a dental sealant on at least one permanent molar within the measurement period
b. **Denominator:** Total number of 3rd grade students reporting for 1 year recall/retention check
c. **Data Source:** Assessment data obtained by program staff using the Basic Screening Survey and recorded in data management system, Smiles Maker.
d. **Rationale/Evidence:** Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish and dental sealant applications.

**Outcome Measure Valuation:**

Numerous studies have documented the value of preventive oral health services, specifically school-based sealants and fluoride varnish applicants in reducing subsequent dental visits, restorative care and emergency visits. Overall children receiving preventive services incur lower dental costs.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 1 project overall.
<table>
<thead>
<tr>
<th>091308902.3.1 PASS 1</th>
<th>3.IT-7.1</th>
<th>Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td></td>
<td>091308902.1.1</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;[P-2]: Establish baseline % of participating 3rd grade students with a dental sealant on at least one permanent first molar&lt;br&gt;Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services&lt;br&gt;Process Milestone 1 Estimated Incentive Payment: $76,298</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;[IT-7.1]: Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth&lt;br&gt;Improvement Target: X% increase over baseline.&lt;br&gt;Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $122,432</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;[IT-7.1]: Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth&lt;br&gt;Improvement Target: X% increase over baseline.&lt;br&gt;Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $177,438</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,298</td>
<td>Year 4 Estimated Outcome Amount: $122,432</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $376,168**
**Identifying Outcome Measure and Provider Information:**

**Title of Outcome Measure (Improvement Target):** IT-7.3 Percentage of children, age 0-6 years, who received a fluoride varnish application during the measurement period. (Non-Stand Alone)

**Unique RHP outcome identification number:** 091308902.3.2 (PASS 1)

**Provider Name:** San Antonio Metropolitan Health District

**TPI:** 082426001

### Outcome Measure Description:

**Improvement Target IT-7.3** Percentage of children, age 0-6 years, who received a fluoride varnish application during the measurement period. (Non-Stand Alone)

Measure will track increase in the number of unduplicated encounters for children ages 0-6 over established baseline of children ages 0-6 enrolled in participating programs

| DY 3 | NA |
| DY 4 | X% Increase over baseline |
| DY 5 | X% Increase over baseline |

### Related Process Milestone-

DY 3  Establish baseline % of participating pre-school children that have received a fluoride varnish application during the measurement period.

### Rationale:

*Outcome improvement targets will be determined in DY3 for implementation in DY4-5*

**IT-7.3 Early Childhood Caries-Fluoride Varnish Applications (Non-Stand Alone)**

Primary caries prevention as offered by primary care providers, including dentists

Number of at risk children, age 0-6, who received one or more fluoride varnish application during the measurement period

- **Numerator:** Total Number of children ages 0-6 that have received at least one fluoride varnish application through the project during the measurement period relative to baseline data
- **Denominator:** Baseline-Total number of children ages 0-6 years that are enrolled in the project target site during the measurement period
- **Data Source:** Program reports; ChildPlus, Smiles Maker or other data management system used by schools and/or Head Start programs
- **Rationale/Evidence:** Identified by the CDC as a preventive measure that has strong evidence demonstrating effectiveness in the prevention of dental caries and allow for low-income high risk children to receive fluoride varnish applications that otherwise may not have the opportunity to receive them.
Outcome Measure Valuation:
Numerous studies have documented the value of preventive oral health services, specifically school-based sealants and fluoride varnish applicants in reducing subsequent dental visits, restorative care and emergency visits. Overall children receiving preventive services incur lower dental costs.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 1 project overall.
<table>
<thead>
<tr>
<th>091308902.3.2 PASS 1</th>
<th>3.IT-7.3</th>
<th>Early Childhood Caries (fluoride applications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>091308902.1.1</td>
<td></td>
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<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone [P-2]: Establish baseline % of participating pre-school children that have received a fluoride varnish application during the measurement period. Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</td>
<td>Outcome Improvement Target 1 [IT-7.3]: Early Childhood Caries (fluoride applications) Improvement Target: X% increase over baseline. Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</td>
<td>Outcome Improvement Target 2 [IT-7.3]: Early Childhood Caries (fluoride applications) Improvement Target: X% increase over baseline. Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $76,298</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $122,432</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,298</td>
<td>Year 4 Estimated Outcome Amount: $122,432</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $376,168</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target): IT-7.6 Percentage of children with urgent dental care needs <em>(Standalone measure)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number: 091308902.3.3 (PASS 1)</td>
</tr>
<tr>
<td>Provider Name: San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>TPI: 082426001</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

**Improvement Target IT-7.6** Percentage of children with urgent dental care needs *(Standalone measure)*

Urgent dental care is defined as needing dental care within 24-48 hours because of signs or symptoms that include pain, infection, and/or swelling.

Measure will track the decrease in the number of children ages 6-9 presenting with urgent dental care needs relative to the established baseline among children participating in project services

| DY 3 | NA |
| DY 4 | X% Decrease from baseline |
| DY 5 | X% Decrease from baseline |

**Related Process Milestone:**

- DY 3 Establish baseline % of participating children presenting with urgent dental care need

**Rationale:**

*Outcome improvement targets will be determined in DY3 for implementation in DY4-5*

**IT-7.6 Urgent Dental Care Needs in Children:**

**Percentage of children with urgent dental care needs (Stand-alone measure)**

- **Numerator:** Number of participating 3rd grade children identified with urgent dental needs participating at 1 year recall/follow-up visit
- **Denominator:** Total number of 3rd grade children returning for 1 year recall/follow up visit
- **Data Source:** Assessment data obtained by program staff using the Basic Screening Survey and recorded in data management system, SmilesMaker.
- **Rationale/Evidence:** Children are less likely to suffer from more severe, urgent oral health problems with adequate and regular access to dental care.

**Outcome Measure Valuation:**

Numerous studies have documented the value of preventive oral health services, specifically school-based sealants and fluoride varnish applicants in reducing subsequent dental visits, restorative care and emergency visits. Overall children receiving preventive services incur lower dental costs.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 1 project overall.
<table>
<thead>
<tr>
<th>091308902.3.3 PASS 1</th>
<th>3.IT-7.6</th>
<th>Urgent Dental Care Needs in Children: Percentage of Children with urgent dental care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>091308902.1.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone [P-2]: Establish baseline % of children presenting with an urgent dental care need Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services Process Milestone 1 Estimated Incentive Payment: $76,298</td>
<td>Outcome Improvement Target 1 [IT-7.6]: Urgent Dental Care Needs in Children: Percentage of Children with urgent dental care needs Improvement Target: X% decrease from baseline. Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services Outcome Improvement Target 1 Estimated Incentive Payment: $122,432</td>
<td>Outcome Improvement Target 2 [IT-7.6]: Urgent Dental Care Needs in Children: Percentage of Children with urgent dental care needs Improvement Target: X% decrease from baseline. Data Source: Service plans, ChildPlus or other data management system, other documentation of dental services Outcome Improvement Target 2 Estimated Incentive Payment: $177,438</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,298</td>
<td>Year 4 Estimated Outcome Amount: $122,432</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $376,168**
Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-2.13: Other Admissions Rate |
| Unique RHP outcome identification number: | 091308902.3.4 (PASS 1) |
| Provider Name: | San Antonio Metropolitan Health District |
| TPI: | 082426001 |

Outcome Measure Description:

**IT 2.13: Other Admissions Rate**

- **Numerator:** Number of teen girls participating in school evidence-based prevention education that are reported delivering babies in the hospital during the measurement period.
- **Denominator:** Population of teen girls receiving evidence-based prevention education and reproductive healthcare services.
- **Data Source:** Bexar County birth certificate data, school district data

| DY 3 | NA |
| DY 4 | X% reduction in teen births compared to reference population |
| DY 5 | X% reduction in teen births compared to reference population |

Related Process Milestone

**DY 3** Establish baseline and comparison data on teen births in intervention school population

Rationale:

The improvement target IT-2.13, Other Admissions Rate, was selected to demonstrate the decrease in teen births and related healthcare expenses associated with childbirth and infant care. This measure does not fully capture the cost of teen childbearing both in health care expenditures and social and economic effects; however, this provides a stable and consistent measure tied to the ultimate project goal of reducing teen pregnancies and repeat teen pregnancies.

Outcome measures were established based on the current high rates of teen births and approximately a 22% rate of repeat teen births occurred in Bexar County in 2010 and the subsequent cost of teen pregnancy on the overall population. Much of this burden is falling on tax payers supporting the Medicaid program. Medicaid costs average $2,500 per infant delivery at as much as $45,000 for an infant treated in the Neonatal Intensive Care Unit. In 2008, Texas taxpayer costs associated with children born to teen mothers included: $221 million for public health care (Medicaid and CHIP); $111 million for child welfare; and, for children who have reached adolescence or young adulthood, $175 million for increased rates of incarceration and $378 million in lost tax revenue due to decreased earnings and spending. According to the Health and Human Services Commission.

Outcome improvement targets will be determined in DY3 for measurement in DY4-5.

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150: InTouch - Medicaid initiative seeks to reduce risk of premature births

Outcome Measure Valuation:

Current high rates of teen births for females 15 to 19 (50.3/1000) and a 22% rate of repeat teen births occurred in Bexar County in 2010 and the subsequent cost of teen pregnancy on the overall population. Much of this burden is falling on tax payers supporting the Medicaid program. Medicaid costs average $2,500 per infant delivery at as much as $45,000 for an infant treated in the Neonatal Intensive Care Unit.152 In 2008, Texas taxpayer costs associated with children born to teen mothers included: $221 million for public health care (Medicaid and CHIP); $111 million for child welfare; and, for children who have reached adolescence or young adulthood, $175 million for increased rates of incarceration and $378 million in lost tax revenue due to decreased earnings and spending.153

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.

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152: InTouch - Medicaid initiative seeks to reduce risk of premature births

<table>
<thead>
<tr>
<th>091308902.3.4 PASS 1</th>
<th>3. IT-2.13</th>
<th>Other Admissions Rate</th>
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</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
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</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>091308902.2.1</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
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</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-2] Establish baseline and comparison group(s) for teen pregnancy prevention through school based intervention Data Source: Bexar County birth certificate data, school district data</td>
<td>Outcome Improvement Target 1 Other Admissions Rate [IT-2.13]: TBD Data Source: Bexar County birth certificate data, school district data</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $333,906</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $208,086</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $208,086</td>
<td>Year 4 Estimated Outcome Amount: $333,906</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,025,914**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT 2.13: Other Admissions Rate |
| Unique RHP outcome identification number: | 091308902.3.5 (PASS 1) |
| Provider Name: | San Antonio Metropolitan Health District |
| TPI: | 082426001 |

### Outcome Measure Description:

**IT 2.13: Other Admissions Rate**
- **Numerator:** # of teen participants in case management services that are reported delivering babies in the hospital during the measurement period
- **Denominator:** Population of teen participants in case management services.
- **Data Source:** Project case management records, Bexar County birth certificate data

| DY 3 | NA |
| DY 4 | X% reduction in teen births compared to reference population |
| DY 5 | X% reduction in teen births compared to reference population |

### Related Process Milestone

| DY 3 | Establish baseline and comparison data on teen births in intervention school population |

### Rationale:

The improvement target IT-2.13, Other Admissions Rate, was selected to demonstrate the decrease in teen births and related healthcare expenses associated with childbirth and infant care. This measure does not fully capture the cost of teen childbearing both in healthcare expenditures and social and economic effects; however it provides a stable and consistent measure tied to the ultimate project goal of reducing teen pregnancies and repeat teen pregnancies. Outcome improvement targets will be determined in DY3 for measurement in DY4-5.

### Outcome Measure Valuation:

Current high rates of teen births for females 15 to 19 (50.3/1000) and a 22% rate of repeat teen births occurred in Bexar County in 2010 and the subsequent cost of teen pregnancy on the overall population. Much of this burden is falling on tax payers supporting the Medicaid program. Medicaid costs average $2,500 per infant delivery at as much as $45,000 for an infant treated in the Neonatal Intensive Care Unit. In 2008, Texas taxpayer costs associated with children born to teen mothers included: $221 million for public health care (Medicaid and CHIP); $111 million for child welfare; and, for children who have reached adolescence or young adulthood, $175 million for increased rates of incarceration and $378 million in lost tax revenue due to decreased earnings and spending. Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.

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154: [InTouch - Medicaid initiative seeks to reduce risk of premature births](http://www.hhsc.state.tx.us/stakeholder/2013/Sept_Oct12/2.html) retrieved on October 9, 2012

<table>
<thead>
<tr>
<th>091308902.3.5</th>
<th>3.IT-2.13</th>
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<tbody>
<tr>
<td>PASS 1</td>
<td></td>
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<tr>
<td>Starting Point/Baseline:</td>
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<table>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Process Milestone 1</td>
<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
<td>Outcome Improvement Target 2</td>
</tr>
<tr>
<td>[P-2]: Establish baseline and comparison group(s) for teen pregnancy prevention through case management intervention</td>
<td>Other Admissions Rate [IT-2.13]: TBD</td>
<td>Other Admissions Rate [IT-2.13]: TBD</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $483,922</td>
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<tr>
<td>Data Source: Project case management records, Bexar County birth certificate data</td>
<td>Data Source: Project case management records, Bexar County birth certificate data</td>
<td>Data Source: Project case management records, Bexar County birth certificate data</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $208,086</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $333,906</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $333,906</td>
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</table>

| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $208,086 | Year 4 Estimated Outcome Amount: $333,906 | Year 5 Estimated Outcome Amount: $483,922 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,025,914**
**Identifying Outcome Measure and Provider Information:**

| Title of Outcome Measure (Improvement Target): IT – 12.6 Other Outcome Improvement Target |
| Unique RHP outcome identification number: 091308902.3.6 (PASS 1) |
| Provider Name: San Antonio Metropolitan Health District |
| TPI: 082426001 |

**Outcome Measure Description:**

A representative sample of each intervention neighborhood will be taken to complete baseline and post-intervention assessments which will include assessment of physical activity level. Outcome measurement efforts will focus on increasing the proportion of participants that are physically active and/or meet the national physical activity standard of 150 minutes of physical activity per week.

**IT – 12.6 Other Outcome Improvement Target**

**Increased reported physical activity level from baseline**

| Numerator: % of residents in target neighborhoods that are physically active |
| Denominator: Total population of target neighborhoods |
| Data Source: County-wide BRFSS and target neighborhood surveys |

| DY 3 | NA |
| DY 4 | X% increase in physical activity level compared to baseline assessment or comparison group |
| DY 5 | X% increase in physical activity level compared to baseline assessment or comparison group |

**Related Process Milestone**

| DY 3 | Establish neighborhood baselines for physical activity level |

**Rationale:**

The outcome measure to increase the proportion of adults who engage in regular physical activity was selected because of its impact on reducing obesity and chronic disease. Increasing physical activity can increase an individual’s ability to lose weight or maintain current weight. The specific improvement target will be determined following the health assessment to be conducted in Year 3 in each of the target neighborhoods.

This indicator will be measured using the Behavior Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control and Prevention on an annual basis. BRFSS is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States annually since 1984. CDC goes through a rigorous process to validate the BRFSS analysis using weighted data, and identifying its confidence interval and p-values to show the precision and accuracy of the data. This outcome measure was selected because it represents a critical health behavior for preventing obesity and obesity-related chronic disease.
**Outcome Measure Valuation:**

Many of the demographic risk factors associated with chronic disease as well as high burdens of chronic disease morbidity and mortality are concentrated in neighborhoods within San Antonio and Bexar County that have traditionally lacked infrastructure to support healthy living and experienced higher rates of poverty. The approach that Metro Health will take in the *Neighborhood Based Physical Activity and Health Promotion Project* will focus on providing a comprehensive neighborhood-based approach to obesity and obesity-related chronic disease prevention.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
<table>
<thead>
<tr>
<th>091308902.3.6 PASS 1</th>
<th>3.IT- 12.6</th>
<th>Other Outcome Improvement Target Increase in physical activity level</th>
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<tr>
<td></td>
<td></td>
<td>San Antonio Metropolitan Health District TPI - 082426001</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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</tr>
<tr>
<td>Starting Point/Baseline:</td>
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<td>TBD</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-2]: Establish neighborhood baselines for physical activity level Data Source: County-wide BRFSS and target neighborhood surveys Process Milestone 1 Estimated Incentive Payment: $138,724</td>
<td>Outcome Improvement Target 1 Increase in physical activity level [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys Outcome Improvement Target 1 Estimated Incentive Payment: $222,604</td>
<td>Outcome Improvement Target 2 Increase in physical activity level [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys Outcome Improvement Target 2 Estimated Incentive Payment: $322,614</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $138,724</td>
<td>Year 4 Estimated Outcome Amount: $222,604</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $683,942</strong></td>
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</table>

1561 ★ RHP 6 Plan ★ March 8, 2013 San Antonio Metropolitan Health District
**Identifying Outcome Measure and Provider Information:**

<table>
<thead>
<tr>
<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT -12.6 Other Outcome Improvement Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique RHP outcome identification number:</td>
<td>091308902.3.7 (PASS 1)</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>TPI:</td>
<td>082426001</td>
</tr>
</tbody>
</table>

**Outcome Measure Description:**

A representative sample of each intervention neighborhood will be taken to complete baseline and post-intervention assessments which will include assessment of fruit and vegetable consumption levels by residents. Outcome measurement efforts will focus on increasing the proportion of participants that report eating fruits and vegetables consistent with the BRFSS questionnaire.

**IT -12.6 Other Outcome Improvement Target**

*Increased reported fruit and vegetable consumption from baseline*

- **Numerator:** % of residents in target neighborhoods reporting eating five or more servings of fruits and vegetables per day
- **Denominator:** Total population of target neighborhoods
- **Data Source:** County-wide BRFSS and target neighborhood surveys

**DY 3** NA

**DY 4** X% increase in fruit and vegetable consumption compared to baseline assessment or comparison group

**DY 5** X% increase in fruit and vegetable consumption compared to baseline assessment or comparison group

**Related Process Milestone**

**DY 3** Establish neighborhood baselines for safety level

**Rationale:**

The outcome measure to increase the percentage of adults who report eating five or more servings of fruits and vegetables per day was selected because of the importance of healthy eating in maintaining a healthy weight and reducing risk for chronic disease.

This indicator will be measured using the Behavior Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control and Prevention on an annual basis. BRFSS is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States annually since 1984. CDC goes through a rigorous process to validate the BRFSS analysis using weighted data, and identifying its confidence interval and p-values to show the precision and accuracy of the data.

**Outcome Measure Valuation:**

Many of the demographic risk factors associated with chronic disease as well as high burdens of chronic disease morbidity and mortality are concentrated in neighborhoods within San Antonio and Bexar County that have traditionally lacked infrastructure to support healthy living and experienced higher rates of poverty. The approach that Metro Health will take in the *Neighborhood Based Physical Activity and Health Promotion Project* will focus on providing a comprehensive neighborhood-based approach to obesity and obesity-related chronic disease prevention.
Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
<table>
<thead>
<tr>
<th>091308902.3.7 PASS 1</th>
<th>3.IT – 12.6</th>
<th>Other Outcome Improvement Target Increase in fruit and vegetable consumption level</th>
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<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td>TPI - 082426001</td>
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**Related Category 1 or 2 Projects:**

<table>
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<tr>
<th>Projects:</th>
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<th>Starting Point/Baseline:</th>
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<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-2]: Establish neighborhood baselines for fruit and vegetable consumption Data Source: County-wide BRFSS and target neighborhood surveys</td>
<td><strong>Outcome Improvement Target 1</strong> Increase in fruit and vegetable consumption level [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $222,604</td>
<td><strong>Outcome Improvement Target 2</strong> Increase in fruit and vegetable consumption level [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $138,724</td>
<td></td>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $322,614</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount: $0**  
**Year 3 Estimated Outcome Amount: $138,724**  
**Year 4 Estimated Outcome Amount: $222,604**  
**Year 5 Estimated Outcome Amount: $322,614**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $683,942**
<table>
<thead>
<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
</tr>
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<tbody>
<tr>
<td>Title of Outcome Measure (Improvement Target): IT – 12.6 Other Outcome Improvement Target</td>
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<tr>
<td>Unique RHP outcome identification number: 091308902.3.8 (PASS 1)</td>
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<td>Provider Name: San Antonio Metropolitan Health District</td>
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<tr>
<td>TPI: 082426001</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Outcome Measure Description:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A representative sample of each intervention neighborhood will be taken to complete baseline and post-intervention assessments which will include assessment of resident body mass index (BMI) and categorization of BMI to overweight (BMI&gt;25) and obese (BMI&gt;30). Outcome measurement efforts will focus on decreasing the proportion of participants that are overweight or obese consistent with the BRFSS questionnaire.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IT – 12.6 Other Outcome Improvement Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease the proportion of residents that are overweight or obese from baseline</td>
</tr>
<tr>
<td>Numerator: % of residents in target neighborhoods with a BMI greater than 25</td>
</tr>
<tr>
<td>Denominator: Total population of target neighborhoods</td>
</tr>
<tr>
<td>Data Source: County-wide BRFSS and target neighborhood surveys</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DY 3</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY 4</td>
<td>X% decrease in residents with a BMI greater than 25 compared to baseline assessment or comparison group</td>
</tr>
<tr>
<td>DY 5</td>
<td>X% decrease in residents with a BMI greater than 25 compared to baseline assessment or comparison group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Process Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY 3 Establish neighborhood baselines for life satisfaction level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rationale:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The outcome measure to decrease the percentage of adults who report being overweight or obese (BMI&gt;25) was selected as obesity is a key risk factor for a variety of chronic diseases and may affect quality of life for individuals. The specific improvement target will be determined following the health assessment to be conducted in Year 3 in each of the target neighborhoods.</td>
</tr>
</tbody>
</table>

This indicator will be measured using the Behavior Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control and Prevention on an annual basis. BRFSS is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States annually since 1984. CDC goes through a rigorous process to validate the BRFSS analysis using weighted data, and identifying its confidence interval and p-values to show the precision and accuracy of the data. This outcome measure was selected because it represents potential improvements in health status and decreased risk for chronic disease.
**Outcome Measure Valuation:**

Many of the demographic risk factors associated with chronic disease as well as high burdens of chronic disease morbidity and mortality are concentrated in neighborhoods within San Antonio and Bexar County that have traditionally lacked infrastructure to support healthy living and experienced higher rates of poverty. The approach that Metro Health will take in the *Neighborhood Based Physical Activity and Health Promotion Project* will focus on providing a comprehensive neighborhood-based approach to obesity and obesity-related chronic disease prevention.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone [P-2]: Establish neighborhood baselines for overweight and obesity levels Data Source: County-wide BRFSS and target neighborhood surveys</td>
<td>Process Milestone 1 Estimated Incentive Payment: $138,724</td>
<td>Outcome Improvement Target 1 Decrease in overweight/obesity [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys</td>
<td>Outcome Improvement Target 2 Decrease in overweight/obesity [IT-12.6]: TBD Data Source: County-wide BRFSS and target neighborhood surveys</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $138,724</td>
<td>Year 4 Estimated Outcome Amount: $222,604</td>
<td>Year 5 Estimated Outcome Amount: $322,614</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $683,942**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c (HbA1c) poor control (>9.0%) – NQF 0059 (Stand-alone measure) |
| Unique RHP outcome identification number: 091308902.3.9 (PASS 1) |
| Provider Name: San Antonio Metropolitan Health District |
| TPI: 082426001 |

### Outcome Measure Description:

Program participants in both the Stanford Diabetes Self-Management Programs and the YMCA Diabetes Prevention Programs will receive the HbA1c test at baseline, and at six and twelve months. Outcome measurement efforts will focus on decreasing the number of participants that have an HbA1c percentage above 9%, which is indicative of poor glucose control.

**IT-1.10 Diabetes care: HbA1c (HbA1c) poor control (>9.0%) – NQF 0059 (Stand-alone measure)**

**Numerator:** Percentage of participants 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

**Denominator:** Participants 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

**Data Source:** Program follow up records/lab results

| DY 3 | NA |
| DY 4 | X% reduction in poor HbA1c control (>9.0%) compared to reference population |
| DY 5 | X% reduction in poor HbA1c control (>9.0%) compared to reference population |

### Related Process Milestone

**DY 3** Establish baseline and comparison data on HbA1c control among intervention population

### Rationale:

HbA1c in poor control is associated with increased incidence of the complications from diabetes, including but not limited to cardiovascular disease, nephropathy, neuropathy, and retinopathy. As HbA1c measures average plasma glucose concentration over prolonged periods of time, it is a more accurate indicator of average blood glucose levels in the months prior to the test. The HbA1c test has also been recommended as a diagnostic tool by the American Diabetes Association in 2010, and undiagnosed participants in the YMCA program will receive appropriate medical referrals if found to have values above 7% at baseline. Outcome improvement targets will be determined in DY3, as the increased percentage of program participants within a range of control as measured by les the 7% has not yet been assessed in the local community-based setting.
Outcome Measure Valuation:

Bexar County hospital discharge data estimated that hospitalizations directly related to diabetes in 2009 accounted for $100 million in costs, which excludes care for emergency room visits that did not result in hospitalization, as well as frequency of doctor visits. Overall, San Antonio as a community bears a very heavy economic toll from diabetes when indirect costs such as disability from complications, work loss, and premature death from related complications are taken into account.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
<table>
<thead>
<tr>
<th>091308902.3.9 PASS 1</th>
<th>3.IT 1.10</th>
<th>Diabetes Care: HbA1c poor control (&gt;9.0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
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<tr>
<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
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<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-2]: Establish baseline and comparison group(s) for poor HbA1c control measurement for project participants Data Source: Program follow up records/lab results</td>
<td><strong>Outcome Improvement Target 1</strong> Diabetes Care: HbA1c poor control [IT-1.10]: TBD Data Source: Program follow up records/lab results</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $155,823</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $97,107</td>
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<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $97,107</td>
<td>Year 4 Estimated Outcome Amount: $155,823</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $478,760
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT 9.2 - ED Appropriate Utilization (reduce ED visits for Diabetes) |
| Unique RHP outcome identification number: | 091308902.3.10 (PASS 1) |
| Provider Name: | San Antonio Metropolitan Health District |
| TPI: | 082426001 |

### Outcome Measure Description:

Program participants in both the Stanford Diabetes Self-Management Programs and the YMCA Diabetes Prevention Programs will be assessed for a reduction in emergency department visits at baseline through a questionnaire, and reassessed at six and twelve months post-intervention. Outcome measurement efforts will focus on decreasing the frequency of emergency department visits among participants.

**IT-9.2 - ED Appropriate Utilization (reduce ED visits for Diabetes)**

- Decreased reported emergency department utilization from baseline, employing Stanford University recommended metric scales
- **Numerator:** Number of participants with a reduction in emergency department visits from baseline to follow up
- **Denominator:** Total number of program participants

**Data Source:** Program questionnaires

| DY 3 | NA |
| DY 4 | X% reduction in emergency department visits compared to baseline assessment population |
| DY 5 | X% reduction in emergency department visits compared to baseline assessment population |

**Related Process Milestone**

- **DY 3** Establish individual and population baseline for emergency department visits

**Rationale:**

Emergency department visits will be assessed at baseline and at six and twelve months for all program participants. Enhanced self-efficacy, improved communication with healthcare providers and social supports will result in lowered percentages in health care utilization for all participants, which is vital in a population with high healthcare costs. Improved community based education on the primary and secondary prevention of diabetes and its complications will reduce utilization and associated costs by promoting lifestyle interventions (YDPP Program) and patient-empowerment in the primary healthcare setting (Stanford Self-Management Programs). The outcome improvement targets will be assessed and defined by DY3.

### Outcome Measure Valuation:

Bexar County hospital discharge data estimated that hospitalizations directly related to diabetes in 2009 accounted for $100 million in costs, which excludes care for emergency room visits that did not result in hospitalization, as well as frequency of doctor visits. Overall, San Antonio as a community bears a very heavy economic toll from diabetes when indirect costs such as disability from complications, work loss, and premature death from related complications are taken into account.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of
the associated category 2 project overall.
<table>
<thead>
<tr>
<th>091308902.3.10 PASS 1</th>
<th>3.IT-9.2</th>
<th>Other Outcome Improvement Target Reduction in emergency department visits (Stanford questionnaire)</th>
</tr>
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<tbody>
<tr>
<td>San Antonio Metropolitan Health District</td>
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<td>TPI - 082426001</td>
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<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
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<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-2]: Establish individual and population baseline for healthcare utilization level among project participants Data Source: Program questionnaires</td>
<td>Outcome Improvement Target 1 Reduction in emergency department visits [IT-1.20]: TBD Data Source: Program questionnaires</td>
<td>Outcome Improvement Target 2 Reduction in emergency department visits [IT-1.20]: TBD Data Source: Program questionnaires</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $97,107</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $155,822</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $255,830</td>
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<td>Year 4 Estimated Outcome Amount: $155,822</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $478,759**
### Identifying Outcome Measure and Provider Information:

| Title of Outcome Measure (Improvement Target): | IT-10.7 Other Outcome Improvement Target |
| Unique RHP outcome identification number: | 091308902.3.11 (PASS 1) |
| Provider Name: | San Antonio Metropolitan Health District |
| TPI: | 082426001 |

### Outcome Measure Description:

Program participants in both the Stanford Diabetes Self-Management Programs and the YMCA Diabetes Prevention Programs will be assessed for their self-reported overall health status at baseline through a questionnaire, and reassessed at six and twelve months post-intervention. Outcome measurement efforts will focus on increasing the proportion of participants that report excellent, very good or good health.

**IT-10.7 Other Outcome Improvement Target**

Increased self-reported overall health status from baseline

**Numerator:**  Number of participants that report excellent, very good or good health

**Denominator:**  Total number of program participants

**Data Source:**  Program questionnaires

| DY 3   | NA |
| DY 4   | X% increase in self-reported overall health status compared to baseline assessment population |
| DY 5   | X% increase in self-reported overall health status compared to baseline assessment population |

### Related Process Milestone

**DY 3**  Establish individual and population baseline for self-reported overall health status

### Rationale:

Self-reported overall health status will be assessed at baseline and at six and twelve months for all program participants. Enhanced self-efficacy, improved communication with healthcare providers, improved access to physical activity resources and social supports will result in improved self perceptions of health. Improved community based education on the primary and secondary prevention of diabetes and its complications will reduce utilization and associated costs by promoting lifestyle interventions (YDPP Program) and patient-empowerment in the primary healthcare setting (Stanford Self-Management Programs). The outcome improvement targets will be assessed and defined by DY3.

### Outcome Measure Valuation:

Bexar County hospital discharge data estimated that hospitalizations directly related to diabetes in 2009 accounted for $100 million in costs, which excludes care for emergency room visits that did not result in hospitalization, as well as frequency of doctor visits. Overall, San Antonio as a community bears a very heavy economic toll from diabetes when indirect costs such as disability from complications, work loss, and premature death from related complications are taken into account.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
| 091308902.3.11 PASS 1 | 3.IT-10.7 | Other Outcome Improvement Target  
Improved self-reported health status |
<table>
<thead>
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<tr>
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| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
| Process Milestone 1  
P-2: Establish individual and population baseline for physical activity level among project participants  
Data Source: Program questionnaires  
Process Milestone 1 Estimated Incentive Payment: $97,106 | Outcome Improvement Target 1  
Improved self-reported health status [IT-10.7]: TBD  
Data Source: Program questionnaires  
Outcome Improvement Target 1 Estimated Incentive Payment: $155,822 | Outcome Improvement Target 2  
Improved self-reported health status [IT-10.7]: TBD  
Data Source: Program questionnaires  
Outcome Improvement Target 2 Estimated Incentive Payment: $255,829 |
| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $97,106 | Year 4 Estimated Outcome Amount: $155,822 | Year 5 Estimated Outcome Amount: $225,829 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $478,757
### Identifying Outcome Measure and Provider Information:

Outcome Measure (Improvement Target): IT-12.5: Other USPSTF Outcome – HIV Screening  
Unique RHP outcome identification number: 091308902.3.12 (PASS 2)  
Provider Name: San Antonio Metropolitan Health District  
TPI: 082426001

### Outcome Measure Description:

**IT-12.5 Other USPSTF-endorsed screening outcome measures**  
Numerator: Number of high risk adults and adolescents (13 years of age or greater) screened for HIV infection  
Denominator: Number of high risk adults and adolescents (13 years of age or greater)  
Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD

Note that this improvement target differs from the project improvement metrics provided for DY3-5 in that the improvement metrics focus on quantifying the specific number of individuals tested for HIV directly by Metro Health STD Branch staff. However, this improvement target seeks to show an increase in the proportion of high risk population that report that they have been screened for HIV. Ideally 100% of high risk individuals would report having been tested for HIV infection.

<p>| | |</p>
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<tbody>
<tr>
<td>DY 3</td>
<td>NA</td>
</tr>
<tr>
<td>DY 4</td>
<td>X% increase in proportion of high risk adults and adolescents (13 years of age or greater) screened for HIV infection</td>
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<tr>
<td>DY 5</td>
<td>X% increase in proportion of high risk adults and adolescents (13 years of age or greater) screened for HIV infection</td>
</tr>
</tbody>
</table>

**Related Process Milestones**  
DY 3 Establish baseline and comparison data on HIV screening rates

**Rationale:**  
The outcome improvement target was selected to demonstrate the increase in the number of high risk people age 13 years and older that are tested for HIV. This information will demonstrate the STD/HIV Branch’s reach in the community and helps to focus and strengthen outreach efforts more efficiently. Testing, education and risk reduction all are part of screening individuals in the community for HIV. The more high risk clients screened and counseled, the faster the ultimate goal of preventing new HIV infections is achieved.

### Outcome Measure Valuation:

Based on recommendations from the United States Preventive Services Task Force (USPSTF) screening for HIV is important for detecting new HIV cases and increased opportunities to treat these individuals. Increasing the number of individuals screened for HIV will lead to an increase in use of clinical services, linkage to care, and ultimately achieve the goal of reducing HIV transmission.

Data shows that one in three Texans with HIV received a late diagnosis of their infection. A late diagnosis is associated with increased morbidity and mortality.

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http://www.uspreventiveservicestaskforce.org/3rduspsft/syphilis/syphilis.htm
diagnosis means the person was also diagnosed with AIDS within one year of an HIV diagnosis.157 Because of the substantial survival advantage resulting from earlier diagnosis of HIV infection when therapy can be initiated before severe immunologic compromise occurs, screening reaches conventional benchmarks for cost-effectiveness even before including the important public health benefit from reduced transmission to sex partners.

Linking patients who have received a diagnosis of HIV infection to prevention and care is essential. HIV screening without such linkage confers little or no benefit to the patient. Although moving patients into care incurs substantial costs, it also triggers sufficient survival benefits that justify the additional costs.158 Even if only a limited fraction of patients who receive HIV-positive results are linked to care, the survival benefits per dollar spent on screening represent good comparative value. Mean cumulative treatment expenditures ranged from $27,275 to $61,615 higher for late than early presenters. After 7 to 8 years in care, the difference was still substantial.159

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.

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157 Hispanics in Texas: Late HIV Diagnosis and Out of Care. DSHS HIV/STD Program. Publication No. 13-13279 (Rev. 10/09).


<table>
<thead>
<tr>
<th>091308902.3.12 PASS 2</th>
<th>3.IT-12.5</th>
<th>Other USPSTF Outcome– HIV Screening</th>
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<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;[P-2]: Establish baseline and comparison group for high risk HIV screening. Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;HIV Screening [IT-12.5]: TBD Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;HIV Screening [IT-12.5]: TBD Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $76,524</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $123,230</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $178,377</td>
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<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,524</td>
<td>Year 4 Estimated Outcome Amount: $123,230</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $378,131
### Identifying Outcome Measure and Provider Information:

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<thead>
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<th>Title of Outcome Measure (Improvement Target):</th>
<th>IT-12.5: Other USPSTF Outcome– Syphilis Screening</th>
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### Outcome Measure Description:

**IT-12.5 Other USPSTF-endorsed screening outcome measures**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of high risk adults and adolescents (13 years of age or greater) screened for syphilis</th>
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<tbody>
<tr>
<td>Denominator</td>
<td>Number of high risk adults and adolescents (13 years of age or greater)</td>
</tr>
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</table>

Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD

Note that this improvement target differs from the project improvement metrics provided for DY3-5 in that the improvement metrics focus on quantifying the specific number of individuals tested for syphilis directly by Metro Health STD Branch staff. However, this improvement target seeks to show an increase in the proportion of high risk population that report that they have been screened for syphilis. Ideally 100% of high risk individuals would report having been tested for syphilis infection.

- **DY 3** N/A
- **DY 4** X% increase in the proportion of high risk adults and adolescents (13 years of age or greater) screened for syphilis
- **DY 5** X% increase in the proportion of high risk adults and adolescents (13 years of age or greater) screened for syphilis

### Related Process Milestones

- **DY 3** Establish baseline and comparison data on syphilis screening rates

### Rationale:

The outcome improvement target was selected to demonstrate the increase in the number of high risk people age 13 years and older that are tested for syphilis. This information will demonstrate the STD/HIV Branch’s reach in the community and helps to focus and strengthen outreach efforts more efficiently. Testing, education and risk reduction all are part of screening individuals in the community for syphilis. The more high risk clients screened and counseled, the faster the ultimate goal of preventing new syphilis infections is achieved.

### Outcome Measure Valuation:

The outcome measure selected addresses a need to screen for syphilis within high risk populations in Bexar County. Bexar County’s primary and secondary syphilis rate in 2011 was 2.3 times higher than the national and state rate. There was a 309% increase in primary and secondary syphilis cases, between the year 2002 and 2011 in the county. Additionally, disparities among racial/ethnic groups in Bexar County are deep, with the 2011 rate for non-Hispanic African Americans, the highest at 20.4, compared to 11.8 for Hispanics and 6.2 for the non-Hispanic Whites.
Based on recommendations from the United States Preventive Services Task Force (USPSTF) screening for syphilis is important for detecting new syphilis cases and increased opportunities to treat these individuals.\textsuperscript{160} Furthermore, the USPSTF states that “the benefits of screening persons at increased risk for syphilis infection substantially outweigh the potential harms.”\textsuperscript{1} If left untreated, even during pregnancy, the syphilis infection can lead to a multitude of costly complications for the individual and even the newborn baby.\textsuperscript{161}

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.


\textsuperscript{161} Centers for Disease Control and Prevention. \textit{Congenital Syphilis ---United States, 2003-2008}. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5914a1.htm
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<tr>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline and comparison group for high risk syphilis screening. Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD</td>
<td>Outcome Improvement Target 1: Syphilis Screening [IT-12.5]: TBD Data Source: San Antonio Metropolitan Health District’s STD*MIS database, primary data collection among high risk populations, other sources TBD</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $123,230</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $178,377</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $76,524</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,524</td>
<td>Year 4 Estimated Outcome Amount: $123,230</td>
<td>Year 5 Estimated Outcome Amount: $178,377</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $378,131
**Identifying Outcome Measure and Provider Information:**

Title of Outcome Measure (Improvement Target): IT – 12.6: Other Outcome Improvement Target – Third Trimester Syphilis Screening in High Risk Women

Unique RHP outcome identification number: 091308902.3.14 (PASS 2)

Provider Name: San Antonio Metropolitan Health District

TPI: 082426001

**Outcome Measure Description:**

*IT- 12.6 Other Outcome Improvement Target*

**Numerator:** Number of high risk pregnant women that receive a third trimester syphilis test

**Denominator:** Number of high risk pregnant women referred to STD case management services which include all women presenting to the STD clinic for any reason and all pregnant women referred by community physicians to the STD surveillance unit.

Data Source: San Antonio Metropolitan Health District’s STD*MIS database, clinic records, case management records, other sources TBD

<table>
<thead>
<tr>
<th>DY 3</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td>DY 4</td>
<td>X% increase in the proportion of high risk pregnant women that receive a third trimester congenital syphilis test</td>
</tr>
<tr>
<td>DY 5</td>
<td>X% increase in the proportion of high risk pregnant women that receive a third trimester congenital syphilis test</td>
</tr>
</tbody>
</table>

**Related Process Milestones**

DY 3 Establish baseline data on third trimester congenital syphilis testing

**Rationale:**

The CDC recommends that all pregnant women living within high prevalence jurisdictions for syphilis be tested once during the first trimester of pregnancy (as required by law in Texas) and once during the third trimester of pregnancy. Bexar County is considered a high prevalence area for syphilis based on current rates. With 18 cases in 2012, the congenital syphilis rate in Bexar County was 75.3 per 100,000 live births, a rate far surpassing any recent year. From 2008-2011 the Bexar County annual rate was 40.9 per 100,000 live births, which is 30% higher than the average rate for Texas for that same period (at 28.6 per 100,000 live births) and five times the national average (8.5 per 100,000 in 2011).

Third trimester syphilis testing is important to the prevention of congenital syphilis due to the potential for infection during the pregnancy after first trimester testing has been completed and because of the effectiveness of available treatments in preventing congenital syphilis if the woman is treated during her pregnancy.

This outcome improvement target was selected to reflect CDC recommendations and to demonstrate the impact of case management activities on third trimester congenital syphilis screening which should lead to the identification and prevention of potential congenital syphilis cases. Additional supportive information will be available based on reports of congenital syphilis cases and case manager files documenting clinical outcomes.
**Outcome Measure Valuation:**

Based on locally obtained data for 2011 the average cost to deliver and treat an infant born with congenital syphilis was $54,677. The average length of hospital stay in these cases was 14 days (ranging from 1 to 45 days). These costs do include the costs to the mother or of ongoing care needed for infants that may be born with significant physical and/or developmental disabilities. Using the 2011 average cost to an infant, the projected cost of care to the 18 infants with a presumptive diagnosis of congenital syphilis in 2012 would be $984,186. Bexar county hospitals could see these costs reduced when a pregnant woman with syphilis is also tested for syphilis in the third trimester, in accordance with CDC STD treatment guidelines\(^{162}\) to prevent congenital syphilis in the infant.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.

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<tr>
<th>091308902.3.14 PASS 2</th>
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<th>Other Outcome Improvement Target – Third Trimester Syphilis Screening in High Risk Women</th>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline data on high risk pregnant women and third trimester screening rates Data Source: San Antonio Metropolitan Health District’s STD*MIS database, clinic records, case management records, other sources TBD</td>
<td>Process Milestone 1 Estimated Incentive Payment: $76,524</td>
<td>Outcome Improvement Target 1 Third Trimester Syphilis Screening in High Risk Women [IT-12.5]: TBD Data Source: San Antonio Metropolitan Health District’s STD*MIS database, clinic records, case management records, other sources TBD</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $178,377</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $76,524</td>
<td>Year 4 Estimated Outcome Amount: $123,230</td>
<td>Year 5 Estimated Outcome Amount: $178,377</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $378,131**
<table>
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<tr>
<th><strong>Identifying Outcome Measure and Provider Information:</strong></th>
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<tr>
<td>Title of Outcome Measure (Improvement Target): IT-8.9: Other Perinatal Outcome–Breastfeeding Initiation</td>
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<td>Unique RHP outcome identification number: 091308902.3.15 (PASS 2)</td>
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<tr>
<td><em>IT-8.9 Other Outcome Improvement Target</em></td>
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<tr>
<td>Numerator: # of postpartum women who initiate breastfeeding who accessed services at Baby Café</td>
</tr>
<tr>
<td>Denominator: # of postpartum women who access services at Baby Café</td>
</tr>
<tr>
<td>Data Source: Baby Café logs/surveys/reports</td>
</tr>
</tbody>
</table>

| DY 3 | NA |
| DY 4 | X % increase in the proportion of postpartum women initiating breastfeeding who accessed services at the Baby Café |
| DY 5 | X % increase in the proportion of postpartum women initiating breastfeeding who accessed services at the Baby Café |

**Related Process Milestone**

DY 3 Establish baseline and comparison data on breastfeeding initiation rates

**Rationale:**
The improvement target IT-8.9, Other Outcome Improvement, was selected to demonstrate that participation in the Baby Café prepares and motivates women to initiate breastfeeding. Outcome improvement targets will be determined in DY3 for measurement in DY4 and DY5.

**Outcome Measure Valuation:**

Breastfeeding is not only the most nutritious way of feeding an infant but also cost effective. Breastfeeding can save parents anywhere between $700 to $3000 dollars during the first year of life (on money not spent on formula). A study by Montgomery et al. also showed that breastfed infants had a cost saving of $112 in Medicaid expenditures during the first six month of life versus formula fed infants. A 2010 UNICEF report assessing the economic benefits of breastfeeding estimated that around $13 billion would be saved if breastfeeding were increased from current levels (13.3%) to 90 percent of women breastfeeding exclusively for six months.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
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<th>091308902.3.15 PASS 2</th>
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| **Year 2**
(10/1/2012 – 9/30/2013) | **Year 3**
(10/1/2013 – 9/30/2014) | **Year 4**
(10/1/2014 – 9/30/2015) | **Year 5**
(10/1/2015 – 9/30/2016) |
| Process Milestone 1 [P-2]: Establish baseline and comparison group for postpartum women initiating breastfeeding. Data Source: Baby Café logs/surveys/reports | Outcome Improvement Target 1 Breastfeeding Initiation [IT-8.9]: TBD Data Source: Baby Café logs/surveys/reports | Outcome Improvement Target 1 Estimated Incentive Payment: $70,417 |
| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $43,728 | Year 4 Estimated Outcome Amount: $70,417 |
| Year 3 Estimated Outcome Amount: $43,728 | Year 4 Estimated Outcome Amount: $70,417 |
| Year 5 Estimated Outcome Amount: $101,930 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $216,075
**Identifying Outcome Measure and Provider Information:**

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<th>Title of Outcome Measure (Improvement Target): IT- 8.9: Other Perinatal Outcome – Breastfeeding Exclusivity</th>
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<tr>
<td>Unique RHP outcome identification number: 091308902.3.16 (PASS 2)</td>
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<td>Provider Name: San Antonio Metropolitan Health District</td>
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<td>TPI: 082426001</td>
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**Outcome Measure Description:**

**IT-8.9 Other Outcome Improvement Target**  
Numerator: # of postpartum women who exclusively breastfeed and who have accessed services at Baby Café  
Denominator: # of postpartum women who access services at Baby Café  
Data Source: Baby Café logs/surveys/reports

| DY 3 | NA |
| DY 4 | X % increase in the proportion of postpartum women that breastfeed exclusively at six months among those that access services at the Baby Café |
| DY 5 | X % increase in the proportion of postpartum women that breastfeed exclusively at six months among those that access services at the Baby Café |

**Related Process Milestone**  
DY 3 Establish baseline and comparison data on breastfeeding exclusivity rates

**Rationale:**  
The improvement target IT-8.9, Other Outcome Improvement, was selected to demonstrate that participation in the Baby Café prepares and motivates women to exclusively breastfeed. Outcome improvement targets will be determined in DY3 for measurement in DY4 and DY5.

**Outcome Measure Valuation:**

Breastfeeding is not only the most nutritious way of feeding an infant but also cost effective. Breastfeeding can save parents anywhere between $700 to $3000 dollars during the first year of life (on money not spent on formula). A study by Montgomery et al. also showed that breastfed infants had a cost saving of $112 in Medicaid expenditures during the first six month of life versus formula fed infants. A 2010 UNICEF report assessing the economic benefits of breastfeeding estimated that around $13 billion would be saved if breastfeeding were increased from current levels (13.3%) to 90 percent of women breastfeeding exclusively for six months.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
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San Antonio Metropolitan Health District | TPI - 082426001 |

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<td><strong>Process Milestone 1</strong> [P-2]: Establish baseline and comparison group for postpartum women exclusively breastfeeding. Data Source: Baby Café logs/surveys/reports</td>
<td><strong>Outcome Improvement Target 1</strong> Breastfeeding Exclusivity [IT-8.9]: TBD Data Source: Baby Café logs/surveys/reports</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $70,417</td>
<td><strong>Outcome Improvement Target 2</strong> Breastfeeding Exclusivity [IT-8.9]: TBD Data Source: Baby Café logs/surveys/reports</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $43,728</td>
<td></td>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $101,929</td>
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</tbody>
</table>

| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $43,728 | Year 4 Estimated Outcome Amount: $70,417 | Year 5 Estimated Outcome Amount: $101,929 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $216,074
Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): IT-8.9: Other Perinatal Outcome–Breastfeeding Duration
Unique RHP outcome identification number: 091308902.3.17 (PASS 2)
Provider Name: San Antonio Metropolitan Health District
TPI: 082426001

Outcome Measure Description:

IT-8.9 Other Outcome Improvement Target
Numerator: # of postpartum women who have extended breastfeeding duration who accessed services at Baby Café
Denominator: # of postpartum women who access services at Baby Café
Data Source: Baby Café logs/surveys/reports

DY 3 NA
DY 4 X % increase in the duration of time breastfeeding among postpartum women who accessed services at the Baby Café
DY 5 X % increase in the duration of time breastfeeding among postpartum women who accessed services at the Baby Café

Related Process Milestone
DY 3 Establish baseline and comparison data on breastfeeding duration rates

Rationale:
The improvement target IT-8.9, Other Outcome Improvement, was selected to demonstrate that participation in the Baby Café prepares and motivates women to extend breastfeeding duration. Outcome improvement targets will be determined in DY3 for measurement in DY4 and DY5.

Outcome Measure Valuation:

Breastfeeding is not only the most nutritious way of feeding an infant but also cost effective. Breastfeeding can save parents anywhere between $700 to $3000 dollars during the first year of life (on money not spent on formula). A study by Montgomery et al. also showed that breastfed infants had a cost saving of $112 in Medicaid expenditures during the first six month of life versus formula fed infants. A 2010 UNICEF report assessing the economic benefits of breastfeeding estimated that around $13 billion would be saved if breastfeeding were increased from current levels (13.3%) to 90 percent of women breastfeeding exclusively for six months.

Valuation for category 3 outcomes are based on the same criteria and ranking as the valuation of the associated category 2 project overall.
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<thead>
<tr>
<th>091308902.3.17</th>
<th>3.IT-8.9</th>
<th>Other Perinatal Outcome—Breastfeeding Duration</th>
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<tr>
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<td>San Antonio Metropolitan Health District</td>
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<td>091308902.2.5</td>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<td>Process Milestone 1 [P-2]: Establish baseline and comparison group for postpartum women who have longer breastfeeding duration rates. Data Source: Baby Café logs/surveys/reports</td>
<td>Outcome Improvement Target 1 – Breastfeeding Duration [IT-8.9]: TBD Data Source: Baby Café logs/surveys/reports</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $70,416</td>
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<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $43,727</td>
<td>Year 4 Estimated Outcome Amount: $70,416</td>
<td>Year 5 Estimated Outcome Amount: $101,929</td>
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</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $216,072
F. Category 4: Population-Focused Improvements (Hospitals only)

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<thead>
<tr>
<th>Performing Provider:</th>
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<tr>
<td>Performing Provider name: VHS San Antonio Partners, LLC d/b/a Baptist Health System</td>
</tr>
<tr>
<td>TP: 159156201</td>
</tr>
</tbody>
</table>

**Domain 1 - Potentially Preventable Admissions**

**Description:**
AHRQ reports that our nation’s hospitals spend approximately 10% of all care provided or up to 4 million patient hospitalizations which may be preventable with effective outpatient care. Reducing preventable hospitalizations is a priority in reducing the rise of healthcare costs.

**Reporting Measures:**
- Congestive heart failure admission rates
- Diabetes admission rates
- Behavioral health and substance abuse admission rate
- Chronic obstructive pulmonary disease or asthma in adults admission rates
- Hypertension admission rates
- Pediatric asthma returns to ED visit within 15 days
- Increase in bacterial pneumonia immunizations
- Increase in influenza immunizations

**Exempt Domains:** Baptist does not expect to report on preventable admissions for Behavioral Health and Substance Abuse as we do not have ambulatory Behavioral Health programs to address preventable admissions.

Baptist does not expect to report on preventable admission rates for diabetes short term complications, since we cannot track the denominator which is # of residents > 18 years with diabetes who have had 2 or more primary care visits in past 12 months within the RHP.

Baptist projects were selected to impact the triple aim goals of assuring patients receive high-quality, patient-centered care, though cost effectiveness and to meet our community needs.

All of our Category 1,2,3 projects relate to and should improve preventable admissions:

**Expand primary care capacity 1.1.1:**
- **Baptist** plans to expand existing sites and add additional primary care physicians over the next four years. This expansion will increase access to vital preventative care and early intervention in acute episodes which should reduce decrease preventable admissions. RHP 6 and Texas overall has a demonstrated need to improve quality of care for prevalent chronic conditions such as diabetes and cardiac care as well as other health disparities.

**Expand specialty care capacity 1.9.2:**
- **Baptist** plans to expand existing sites and add additional specialty care physicians over the next four years. This expansion will increase access to vital preventative care and early intervention in acute episodes which should reduce decrease preventable admissions. RHP 6 and Texas overall has a demonstrated need to improve access and quality of care in cardiac disease, maternal/infant care and behavioral health all of which will be addressed through BHS plans.
for expansion of specialty care.

**Enhance performance improvement and reporting capacity 1.10.1**

**Design, develop and implement a program of continuous, rapid process improvement methodology to improve quality/efficiency 2.8.1:**

- Through the implementation of lean and six sigma performance improvement methodology in our health system, **Baptist** will create a PI infrastructure focused on educating employees and physicians. Through the implementation of these tools we will change work processes, improve cost efficiency, **improve patient care and outcomes**, and address RHP goals of
  - Triple Aim - Improve health care infrastructure to better serve Medicaid and uninsured
  - Further develop and maintain a coordinated care delivery system
  - Improve outcomes while containing cost growth

Through the PI structure and training, we will examine clinical care processes seeking reduced variation, improve patient teaching and transitional care, change physician practices, all of which can lead to reduced inpatient care and prevent admissions.

Baptist expects these projects to result in improved outcomes for this domain’s measures to benefit the RHP population by reducing preventable admissions, improving overall ambulatory health management and providing improved, effective inpatient care for chronic conditions.

**Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Baptist took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

**Performing Provider:**

Performing Provider name: VHS San Antonio Partners, LLC d/b/a Baptist Health System

TPI: 159156201

**Domain 2: Potentially Preventable Readmissions – 30 days**

**Description:**

**REPORTING MEASURES:**

- Congestive Heart Failure (HF): 30 Day Readmissions
- Diabetes: 30-Day Readmissions
- Behavioral health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30-Day Readmissions
- Pediatric Asthma: 30-Day Readmissions
- All–Cause: 30-Day Readmissions

Exempt domain(s): None known at this time
Baptist projects were selected to impact the triple aim goals of assuring patients receive high-quality, patient-centered care, though cost effectiveness and to meet our community needs.

All of our Category 1,2,3 projects relate to and should improve 30 day readmissions:

Expand primary care capacity 1.1.1
Expand specialty care capacity 1.9.2
Enhance performance improvement and reporting capacity 1.10.1
Design, develop and implement a program of continuous, rapid process improvement methodology to improve quality/efficiency 2.8.1

Improving access to primary and specialty care and linking the patient and provider post acute care status will result in decreased readmissions through appropriate ambulatory management.

BHS is developing teams at each hospital for continuous review of the patient’s experience that trigger re-admission including representatives from Nursing, Case Management, Social Service and Medical staff. The centerpiece of the BHS re-admission strategy is early intervention through a team approach. BHS has a process to identify both high risk and moderate risk patients for re-admission. With readmission a notification is sent electronically to Case Managers who then visit the patients. During rounding, the Case Manager in conjunction with nursing and physicians communicate and monitor handoffs together. This helps the patient and family members understand the diagnosis, treatment plan and post discharge care. It also facilitates and enhances communication between the multi-disciplinary care team.

BHS will work with the medical staff to complete the discharge summaries on all discharged patients within 24 hours post discharge. Copies are sent to the primary/referring physician to facilitate continuity of care. We are also engaging the medical staff to use the physician portal by granting all affiliated physicians access to the electronic record.

We are currently using PI to simplify what we teach patients and assess patient's understanding of what has been taught and then revising. We will use “Teach Back” during hospitalization, follow-up phone calls assessing patient and family caregiver understanding of instructions as well as ability to perform self care. Using PI tools we continue review of processes and policies to standardize care, ensuring appropriate treatment and discharge instructions.

We will be recruiting Case Managers for Transition Care Manager (TCM) position at all five hospitals. Their primary responsibility is to improve discharge planning and transition out of the hospital by improving that transition, providing care coordination at the interfaces between care settings as well as enhancing coaching, education and self management. Part of the TCM responsibility will be to work with other health care providers for follow up visits of at risk patients. TCMs will ensure that chronically ill patients and elderly have appointments with their primary physicians, scheduled by the TCMs. The TCM will provide the physician with an electronic summary of the discharge summary, make follow up call to the patients do the patient sees their primary care physician within five days.

We also continue to develop partnerships and relationships with our Home Health Agencies and Nursing Homes to ensure that they are equipped with the resources to take care of the patients assigned to their service and care.

BHS is enhancing the admission reconciliation of medications. The patient and family caregivers
are involved during the medication history taken at admission. The assessment includes over-the-counter and alternative or herbal medicines. The medication reconciliation is documented as part of the medical record.

**Valuation:**

Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Baptist took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

**Performing Provider:**

Performing Provider name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201

**Domain 3: Potentially Preventable Complications**

**Description:**

Reporting Measure: Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed in Domain 3 in DY 4-5.

The metrics for Potentially Preventable Complications (PPC) span the full spectrum of care provided and intersect within the populations cared for in cardiovascular, cancer, diabetic, maternal and child health, as well as behavioral health as outlined in Categories 1, 2 and 3. Efforts to improve organizational performance improvement acumen assist in reducing the incidences of PPCs.

Baptist Health System (BHS) actively monitors and sets safety and improvement goals to meet or exceed the state/national averages for all of the PPCs. The system utilizes improvement tools such as Crimson, a quality and financial database based on coded data, to provide information related to PPCs down to the individual practitioner level. This data can then provide the team valuable insights for system improvements as well as information to the individual provider via the Ongoing Performance Practice Evaluation (OPPE).

Reduction in the PPC impacts outcomes for all acute care populations, reduces length of stay, and reduces the overall cost of care. To provide examples of the system’s focus on reducing PPCs the following is the focus on some of the current improvement efforts that tie to our Category 1 and 2 projects:

**Enhance performance improvement and reporting capacity 1.10.1**

Design, develop and implement a program of continuous, rapid process improvement methodology to improve quality/efficiency 2.8.1:
Cardiovascular Co-Management Agreement:
- Cardiovascular improvements and a focused approach within the cardiovascular surgery arena strives to reduce postoperative infections, sepsis, post-hemorrhage, AMI, ventricular fibrillation, etc. Efforts on CABG procedures initially focus on achieving metric goals to national and/or state averages with the outcome to improve to the top decile performance. Several efforts are underway to create these improvements; this includes a cardiovascular co-management agreement that encompasses superior care as outlined by the Society for Thoracic Surgeons metrics – that include many of these particular PPCs. A Cardiovascular Surgery Site Infection Task Force has been implemented to bring together Surgeons, Operational leaders and Infection Prevention to consider operational and process improvements in order to reduce the incidence of postoperative infections.

DRG-Care Reliability Lean Team:
- Improvements within the bowel procedure (APR-DRG 221) arena will have an anticipated reduction in major and other gastrointestinal complications, postoperative infections, gastrointestinal ostomy complications, and infections due to central venous catheters. With a focused improvement in the utilization of TPN there can be a direct correlation found with the evidence of a decrease in infections related to central venous catheters.

Beyond the targeted areas, all patients receive care that focuses on reduction of PPC. In the current year, there are targeted efforts to improve sepsis recognition and timely treatment as well as timely and appropriate screening and treatment for VTE. BHS uses data obtained from the E-ICU and Emergency Services to evaluate evidence-based care provided.

Baptist Health System is also actively focused on “driving to zero” with hospital-acquired infections which account for a number of the PPCs. BHS participates in a collaborative with the Texas Medical Care Foundation (TMF) to reduce the incidence of catheter associated urinary tract infections (CAUTI). This collaboration has resulted in significant improvements in the past quarter 2012. This was accomplished with a grass-roots education targeted to the bedside nurse. Additionally, in January 2013, the system will participate in the TMF collaborative to reduce the incidence of surgical site infections (SSI) as well as a clostridium difficile colitis in the inpatient populations.

Valuation:
Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Baptist took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
Performing Provider:
Performing Provider name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201

Domain 4: Patient-Centered Healthcare

Description:

Reporting Measures:
- **Patient Satisfaction**
- **Medication management**

To provide examples of the system’s focus on improving patient satisfaction and medication management, the following is the focus on some of the current improvement efforts that tie to Category 1 and 2 projects:

**Enhance performance improvement and reporting capacity 1.10.1**

**Design, develop and implement a program of continuous, rapid process improvement methodology to improve quality/efficiency 2.8.1:**

Patient Satisfaction is tracked via Press Ganey HCHAPs. MTD scoring is reported weekly although all of our Department Directors have system access to review daily. Each facility conducts weekly patient experience meetings with department staffs that are not at goal. PI tools are used intradepartmentally to evaluate processes such as the effectiveness of hourly rounding, patient communication boards, bedside shift reporting, key words at key times and numerous other “Best Practice” techniques. Through the Studer organization Baptist contracts for a coach that assists both facility senior leaders as well as new and experienced department leaders on “must haves” to improve patient experience.

We currently have a monthly scorecard for all five facilities and those results are shared at employee department meetings, employee CEO forums and at all medical staff meetings. Most of our physician contracts have patient experience tied to reimbursement.

Baptist is currently evaluating a rapid cycle improvement movement to reach and sustain patient satisfaction at the 75th percentile.

To improve medication management, BHS pharmacy department will begin to deploy a pharmacist at the point of care to facilitate the medication reconciliation process. The clinical pharmacist will review medications, teach patients regarding new medications or medication changes and review discontinued medications. They will also track adverse drug events and serve as a resource to the bedside nurse.

Valuation:
Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Baptist took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
Performing Provider:
Performing Provider name: VHS San Antonio Partners, LLC d/b/a Baptist Health System
TPI: 159156201
Domain 5: Emergency Department

Description:
Reporting Measures:
- Admit decision to departure time for admitted patients

To provide examples of the system’s focus on improving patient satisfaction and medication management, the following is the focus on some of the current improvement efforts that tie to Category 1 and 2 projects:
Enhance performance improvement and reporting capacity 1.10.1
Design, develop and implement a program of continuous, rapid process improvement methodology to improve quality/efficiency 2.8.1

The disposition to admit metric is monitored monthly by Vanguard and included in executive monthly performance reviews. Using PI processes and techniques, Baptist uses data and analyzes, breaking down the time into the following components: decision to admit, time to get orders and time to move to nursing unit. As an example, this PI process identified opportunity to use bridge orders that would eliminate the time associated with waiting for admission orders.

We will pilot a transition team to aid in a patient-centered safe and timely transition of patients from ED care to care on the floor and ensure orders are not missed, care continues, and patient is moved to appropriate level of care.

BHS is adding hospitalist mid-level providers during peak hours to work with nocturnists between admissions to provide cross call coverage and support patient codes which will allow for a smoother inpatient admission flow.

BHS has a system-wide initiative on increasing discharge by noon percentages. The point of this is to create capacity and precede the demand peak from the ED allowing for quicker patient transition to the floor. The delays to discharges are discussed and analyzed in several forums including daily nursing leadership huddles and daily hospitalist meetings.

We will continue to evaluate and trial new and streamlined processes to impact the time the patient waits in the ED before being transferred to a nursing unit bed as the PI tools yield new information.

Valuation:
Baptist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Baptist took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
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<tbody>
<tr>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td>$568,648</td>
<td>$263,655</td>
<td></td>
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<tr>
<td>Estimated Maximum Incentive Amount</td>
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<td>1: October 1 – March 31</td>
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<tr>
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<td>Includes a list of 64 measures identified in the RHP Planning Protocol.</td>
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## Domain 4: Patient Centered Healthcare

**Patient Satisfaction – HCAHPS**

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**Medication Management**

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## Domain 5: Emergency Department

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**OPTIONAL Domain 6: Children and Adult Core Measures**

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**Grand Total Payments Across Category 4**

| $568,648 | $1,318,275 | $1,410,248 | $1,532,878 |
Performing Provider:
Performing Provider name: Children’s Hospital of San Antonio
TPI: 020844903

Domain 1: Potentially Preventable Admissions

Description:
According to the Agency for Healthcare Research and Quality, American hospitals spent nearly $31 billion, 10 percent of their total patient care budget, in 2006 on more than 4 million patient stays that could possibly have been prevented with timely and effective ambulatory care. Reducing preventable hospitalizations is a proven way to help reduce these rising costs.

Each project submitted by Children’s Hospital of San Antonio will help to decrease preventable admissions:

- **Establish More Primary Care Clinics (1.1.1):** Children’s hospital of San Antonio (CHofSA) will develop a geographically dispersed network of pediatric primary care clinics throughout Bexar County to enhance access points, increase available appointment times, and promote patient awareness of available services and overall primary care capacity, all of which will ultimately result in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

- **Improve Access to Specialty Care (1.9.2):** The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services.

Children’s Hospital of San Antonio expects the above projects to result in improved outcomes for the following measures under this domain:

1. Decrease in the number of pediatric asthma patients that return to the ED for treatment within 15 days of their last ED visit
2. Increase in bacterial pneumonia immunizations
3. Increase in influenza immunizations

Children’s Hospital of San Antonio requests to be exempt from reporting on the following measures due to the identified age specifications:

1. Congestive Heart Failure Admission Rates (patients 18 and older)
2. Diabetes Admission Rates (patients 18 and older)
3. Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rates (patients 18 and older)
4. Hypertension Admission Rates (patients 18 and older)

Additionally, Children’s Hospital of San Antonio does not offer behavioral health and substance abuse services; therefore it requests to be exempt from reporting on this specific measure under this domain.

On a monthly basis, Children’s Hospital of San Antonio will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.
**Valuation:**

In valuing this domain, Children’s Hospital of San Antonio took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a significant role in reducing preventable admissions by ensuring that patients receive the right care, in the right setting, at the right time.

---

**Performing Provider:**

Performing Provider name: Children’s Hospital of San Antonio  
TPI: 020844903  
**Domain 2: Potentially Preventable Readmissions**

**Description:**

A number of studies have demonstrated that improvements in care at the time of patient discharge can significantly reduce 30-day readmission rates. Hospitals, in collaboration with other healthcare providers, can take a number of actions to reduce readmissions: ensure patients are clinically ready at discharge; reduce risk of infection; reconcile medications; improve communications among providers involved in transition of care; implement strategies that promote disease management; and educate patients about symptoms to monitor, whom to contact with questions, and where and when to seek follow-up care (source: National Quality Forum Measure Submission and Evaluation Worksheet 5.0).

Each project submitted by Children’s Hospital of San Antonio will help to reduce readmission:

- **Establish More Primary Care Clinics (1.1.1):** The primary goal of this objective is to expand the capacity of Pediatric primary care to better accommodate the needs of children in the community. Increased access to primary care allows patients to receive the right care at the right time in the right setting, which will result in fewer readmissions.

- **Improve Access to Specialty Care (1.9.2):** The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services.

Children’s Hospital of San Antonio expects the above projects to result in improved outcomes for the following measures under this domain:

1. Decrease in pediatric asthma 30-day readmissions.

Children’s Hospital of San Antonio requests to be exempt from reporting on the following measures due to the identified age specifications:

1. Congestive Heart Failure 30-day Readmissions (patients 18 and older)
2. Diabetes 30-day Readmissions (patients 18 and older)
3. Chronic Obstructive Pulmonary Disease 30-day Readmissions (patients 18 and older)
4. Stroke 30-day Readmissions (patients 18 and older)
5. All-Cause 30-day Readmissions (patients 18 and older)

Additionally, Children’s Hospital of San Antonio does not offer behavioral health and substance abuse services; therefore it requests to be exempt from reporting on this specific measure under this domain.

On a monthly basis, Children’s Hospital of San Antonio will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, Children’s Hospital of San Antonio took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a significant role in reducing readmissions by ensuring that patients receive the right care, in the right setting, at the right time.

### Performing Provider:

Performing Provider name: Children’s Hospital of San Antonio  
TPI: 020844903

**Domain 3: Potentially Preventable Complications**

**Description:**

Inpatient hospital complications can result in substantial adverse outcomes for patients and in some cases can have life threatening consequences. These events often result in increased hospital stays and consume additional costly healthcare resources. Reducing complications has been identified as an approach to improving care and reducing healthcare costs.

Each Children’s Hospital of San Antonio project will help to reduce complications:

- **Establish More Primary Care Clinics (1.1.1):** The primary goal of this objective is to expand the capacity of pediatric primary care to better accommodate the needs of children in the community. By expanding access to pediatric primary care, patients will have increased access to preventative care, which can help reduce complications associated with existing chronic conditions.

- **Improve Access to Specialty Care (1.9.2):** The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services. This increase will result in more available appointment times, increased patient awareness of available services, improved patient health outcomes, improved patient satisfaction, improvement in utilization patterns, and reduction in cost of services.

Children’s Hospital of San Antonio expects the above projects to result in improved outcomes for the 64 measures under this domain.
On a monthly basis, Children’s Hospital of San Antonio will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, Children’s Hospital of San Antonio took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a significant role in reducing preventable complications by ensuring that patients receive the right care, in the right setting, at the right time.

---

**Performing Provider**

Performing Provider name: Children’s Hospital of San Antonio  
TPI: 020844903

**Domain 4: Patient-Centered Healthcare**

**Description:**

The following two projects are Outpatient focused and therefore will have no impact on this domain.

- **Establish More Primary Care Clinics (1.1.1): (TPI Pending).1.2:** The primary goal of this objective is to expand the capacity of Pediatric primary care to better accommodate the needs of children in the community. Increased access to primary care allows patients to receive the right care at the right time in the right setting, which will result in a better patient experience.

- **Improve Access to Specialty Care (1.9.2) (TPI Pending).1.1:** The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services. This increase will result in more available appointment times, increased patient awareness of available services, improved patient health outcomes, improved patient satisfaction, improvement in utilization patterns, and reduction in cost of services.

**Valuation:**

In valuing this domain, Children’s Hospital of San Antonio took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a role in improving the patient experience by ensuring that patients receive the right care, in the right setting, at the right time.
Performing Provider:

Performing Provider name: Children’s Hospital of San Antonio  
TPI: 020844903  
**Domain 5: Emergency Department**

**Description:**

Evidence indicates that reducing the time patients remain in the emergency department can improve access to treatment and improve quality of care. Emergency department overcrowding and increased demand for emergency resources leads to ED diversions, prolonged patient wait times, decreased patient satisfaction, rushed treatment environments, and poor patient outcomes.

Each Children’s Hospital of San Antonio project will help to improve admit decision time:

- **Establish More Primary Care Clinics (1.1.1):** The primary goal of this objective is to expand the capacity of Pediatric primary care to better accommodate the needs of children in the community. In doing so, patients will have a provider who is familiar with their healthcare needs and can make quick and informed decisions when contacted by the ED.

- **Improve Access to Specialty Care (1.9.2):** The primary goal of this project is to increase the capacity to provide pediatric sub-specialty care services and the availability of targeted specialty providers to better accommodate the high demand for such services. This increase will result in more available appointment times, increased patient awareness of available services, improved patient health outcomes, improved patient satisfaction, improvement in utilization patterns, and reduction in cost of services.

Children’s Hospital of San Antonio expects the above projects to result in improved outcomes for the following measures under this domain:

1. Improved admit decision time to ED departure time for admitted patients.

On a monthly basis, Children’s Hospital of San Antonio will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, Children’s Hospital of San Antonio took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a role in improving admit decision time by ensuring that patients receive the right care, in the right setting, at the right time.
## Category 4: Population-Focused Measures

**Children’s Hospital of San Antonio** / 020844903

### Year 2 (10/1/2012 – 9/30/2013)

**Capability to Report Category 4**

<table>
<thead>
<tr>
<th>Domain 1 - Estimated Maximum Incentive Amount</th>
<th>$284,324</th>
</tr>
</thead>
</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

<table>
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<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>1: October 1 – March 31</td>
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<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
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<td>$141,025</td>
<td>$153,288</td>
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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$131,828</td>
<td>$141,025</td>
<td>$153,288</td>
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</table>

**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>1: October 1 – March 31</td>
<td>1: October 1 – March 31</td>
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<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td>$141,025</td>
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**Milestone**

- Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.
- Status report submitted to HHSC confirming system capability to report Domains 3.
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<tr>
<td>Domain 5: Emergency Department</td>
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<td>Measurement period for report</td>
<td></td>
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<td>Planned Reporting Period: 1 or 2</td>
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<td>2: April 1 – Sept. 30</td>
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<td>OPTIONAL Domain 6: Children and Adult Core Measures</td>
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Performing Provider:
Performing Provider name: CHRISTUS Santa Rosa Health System
TPI: 020844901

Domain 1: Potentially Preventable Admissions

Description:
According to the Agency for Healthcare Research and Quality, American hospitals spent nearly $31 billion, 10 percent of their total patient care budget, in 2006 on more than 4 million patient stays that could possibly have been prevented with timely and effective ambulatory care. Reducing preventable hospitalizations is a proven way to help reduce these rising costs. Each CHRISTUS Santa Rosa Health System project was carefully selected for its ability to impact the triple aim goals of assuring patients receive high-quality and patient-centered care, in the most cost effective ways.

- **Expand Primary Care Capacity (1.1.2):** CSRHS plans to expand beyond its existing clinic space and add an additional 4 primary care physicians over the next four years. In doing so, CSRHS will increase access to much needed preventative care, which will result in a decrease preventable admissions.

- **Patient-Centered Medical Homes (2.1.2):** As a result of this project, CSRHS expects to see a marked increase in access to primary care and a significant improvement in the management of chronic conditions over the next 5 years, which has been proven to successfully reduce the number of unnecessary hospital admissions.

- **Care Transitions – Intervention Nurse Program (2.12.1):** The primary goal of this project is to significantly reduce unplanned re-admissions for patient populations with the principal diagnosis of congestive heart failure (CHF), pneumonia (PN) and acute myocardial infarction (AMI).

CHRISTUS Santa Rosa Health System expects the above projects to result in improved outcomes for the following measures under this domain:

4. Decrease in congestive heart failure admission rates
5. Decrease in diabetes admission rates
6. Decrease in obstructive pulmonary disease or asthma in adults admission rates
7. Decrease in hypertension admission rates
8. Decrease in the number of pediatric asthma patients that return to the ED for treatment within 15 days of their last ED visit
9. Increase in bacterial pneumonia immunizations
10. Increase in influenza immunizations

CHRISTUS Santa Rosa Health System does not offer behavioral health and substance abuse services; therefore it requests to be exempt from reporting on this specific measure under this domain.

On a monthly basis, CHRISTUS Santa Rosa will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.
Valuation:
In valuing this domain, CHRISTUS Santa Rosa took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each of the three submitted projects will play a significant role in reducing preventable admissions by ensuring that patients receive the right care, in the right setting, at the right time.

Performing Provider:
Performing Provider name: CHRISTUS Santa Rosa Health System
TPI: 020844901
Domain 2: Potentially Preventable Readmissions – 30 days
Description:
A number of studies have demonstrated that improvements in care at the time of patient discharge can significantly reduce 30-day readmission rates. Hospitals, in collaboration with other healthcare providers, can take a number of actions to reduce readmissions: ensure patients are clinically ready at discharge; reduce risk of infection; reconcile medications; improve communications among providers involved in transition of care; implement strategies that promote disease management; and educate patients about symptoms to monitor, whom to contact with questions, and where and when to seek follow-up care (source: National Quality Forum Measure Submission and Evaluation Worksheet 5.0).

Each CHRISTUS Santa Rosa Health System project will help to reduce readmissions.

- **Expand Primary Care Capacity (1.1.2):** CSRHS plans to expand beyond its existing clinic space and add an additional 4 primary care physicians over the next four years. In doing so, CSRHS will increase access to much needed preventative care.

- **Patient-Centered Medical Homes (2.1.2):** As a result of this project, CSRHS expects to see a marked increase in access to primary care and a significant improvement in the management of chronic conditions over the next 5 years. This project addresses demonstrated public health challenges in the community by catering to the complex, chronic care needs of the population; improving adherence to care plans through comprehensive preventative and primary care services; providing active follow-up in between office visits; and, promoting continuity of care.

- **Care Transitions – Intervention Nurse Program (2.12.1):** This project will create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.
CHRISTUS Santa Rosa Health System expects the above projects to result in improved outcomes for the following measures under this domain:

2. Decrease in congestive heart failure 30-day readmissions.
3. Decrease in diabetes 30-day readmissions.
4. Decrease in chronic obstructive pulmonary disease 30-day readmissions.
5. Decrease in stroke 30-day readmissions.
6. Decrease in pediatric asthma 30-day readmissions.
7. Decrease in all-cause 30-day readmissions.

CHRISTUS Santa Rosa Health System does not offer behavioral health and substance abuse services; therefore it requests to be exempt from reporting on this specific measure under this domain.

On a monthly basis, CHRISTUS Santa Rosa will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, CHRISTUS Santa Rosa took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each of the three submitted projects will play a significant role in reducing readmissions by ensuring that patients receive the right care, in the right setting, at the right time.

**Performing Provider:**

Performing Provider name: CHRISTUS Santa Rosa Health System
TPI: 020844901

**Domain 3: Potentially Preventable Complications**

**Description:**

Inpatient hospital complications can result in substantial adverse outcomes for patients and in some cases can have life threatening consequences. These events often result in increased hospital stays and consume additional costly healthcare resources. Reducing complications has been identified as an approach to improving care and reducing healthcare costs.

Each CHRISTUS Santa Rosa Health System project will help to reduce complications:

- **Expand Primary Care Capacity (1.1.2):** By expanding access to primary care, patients will have increased access to preventative care, which can help reduce complications associated with existing chronic conditions.
- **Patient-Centered Medical Homes (2.1.2):** As a result of this project, CSRHS expects to see a marked increase in access to primary care and a significant improvement in the management of chronic conditions over the next 5 years. This project addresses
demonstrated public health challenges in the community by catering to the complex, chronic care needs of the population; improving adherence to care plans through comprehensive preventative and primary care services; providing active follow-up in between office visits; and, promoting continuity of care.

- **Care Transitions – Intervention Nurse Program (2.12.1):** This project will create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for complications and avoidable readmissions.

CHRISTUS Santa Rosa Health System expects the above projects to result in improved outcomes for the 64 measures under this domain.

On a monthly basis, CHRISTUS Santa Rosa will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, CHRISTUS Santa Rosa took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each of the three submitted projects will play a significant role in reducing complications by ensuring that patients receive the right care, in the right setting, at the right time.

**Performing Provider:**

Performing Provider name: CHRISTUS Santa Rosa Health System
TPI: 020844901

**Domain 4: Patient-Centered Healthcare**

**Description:**

Patient-centered care is an effective method for improving the health of the population and helping to reduce the rising costs of healthcare. Improving the patient experience will require a redesign of primary care to meet the needs of patients for timely, patient-centered, continuous, and coordinated care and must be centered on cultural change at the organizational level. Each CHRISTUS Santa Rosa Health System project was carefully selected for its ability to impact the triple aim goals of assuring patients receive high-quality and patient-centered care, in the most cost effective ways.

- **Expand Primary Care Capacity (1.1.2) 020844901.1.1:** By expanding access to primary care, patients will have increased access to preventative care, which will improve quality outcomes and improve overall patient satisfaction.

- **Patient-Centered Medical Homes (2.1.2) 020844901.2.1:** This project meets the Triple Aim goals of the Waiver by promoting better health, better patient experience of care, and ultimately better cost-effectiveness By providing the right care at the right time and in the right setting, patients not only have better access to primary care, they may see their health
improved, will rely less on costly ED visits, will incur fewer avoidable hospital stays and report greater patient satisfaction.

- **Care Transitions – Intervention Nurse Program (2.12.1) 020844901.2.2:** The Care Transitions Intervention was designed in response to the need for a patient-centered, interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners. This project will create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for complications and avoidable readmissions.

Of the three projects listed below, Care Transitions is the only one focused on the inpatient setting. CHRISTUS Santa Rosa Health System expects this project to result in improved outcomes for the following measures under this domain:

1. Improved patient satisfaction.
2. Improved medication management.

On a monthly basis, CHRISTUS Santa Rosa will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, CHRISTUS Santa Rosa took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each of the three submitted projects will play a significant role in improving the patient experience by ensuring that patients receive the right care, in the right setting, at the right time.

**Performing Provider:**

Performing Provider name: CHRISTUS Santa Rosa Health System  
TPI: 020844901  
**Domain 5: Emergency Department**  
**Description:**

Evidence indicates that reducing the time patients remain in the emergency department can improve access to treatment and improve quality of care. Emergency department overcrowding and increased demand for emergency resources leads to ED diversions, prolonged patient wait times, decreased patient satisfaction, rushed treatment environments, and poor patient outcomes.

CHRISTUS Santa Rosa Health System has two projects that will help to improve admit decision time:
- **Expand Primary Care Capacity (1.1.2):** By expanding access to primary care, patients will have a provider who is familiar with their healthcare needs and can make quick and informed decisions when contacted by the ED.

- **Patient-Centered Medical Homes (2.1.2):** This project addresses demonstrated public health challenges in the community by catering to the complex, chronic care needs of the population; improving adherence to care plans through comprehensive preventative and primary care services; providing active follow-up in between office visits; and, promoting continuity of care.

CHRISTUS Santa Rosa Health System expects the above projects to result in improved outcomes for the following measures under this domain:

2. Improved admit decision time to ED departure time for admitted patients.

On a monthly basis, CHRISTUS Santa Rosa will review our Electronic Health Records (EHR) for all patient cases for relevant medical record coding that identifies the specific patient populations to be monitored.

**Valuation:**

In valuing this domain, CHRISTUS Santa Rosa took into account the extent to which each of its projects would potentially impact the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

Each submitted project will play a role in improving admit decision time by ensuring that patients receive the right care, in the right setting, at the right time.
## Category 4: Population-Focused Measures
CHRISTUS Santa Rosa Health System / 020844901

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<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$284,324</td>
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<td>$131,828</td>
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### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $131,828

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$131,828</td>
<td>$141,025</td>
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### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $131,828

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$131,828</td>
<td>$141,025</td>
<td>$153,288</td>
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</table>

### Domain 3: Potentially Preventable Complications (PPCs)
Includes a list of 64 measures identified in the RHP Planning Protocol.

- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $141,025

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<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
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<td>$153,288</td>
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### Estimated Maximum Incentive Amount

- **Year 2:** $284,324
- **Year 3:** $131,828
- **Year 4:** $141,025
- **Year 5:** $153,288
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<tr>
<th><strong>Domain 4: Patient Centered Healthcare</strong></th>
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<td><strong>Patient Satisfaction - HCAHPS</strong></td>
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| **Medication Management**                |
| Planned Reporting Period: 1 or 2         | 2: April 1 – Sept. 30 | 2: April 1 – Sept. 30 | 2: April 1 – Sept. 30 |

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<td>$141,025</td>
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<td>$153,288</td>
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| **Domain 5: Emergency Department**            |
| Planned Reporting Period: 1 or 2             | 2: April 1 – Sept. 30 | 2: April 1 – Sept. 30 | 2: April 1 – Sept. 30 |

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<tr>
<th><strong>Domain 5 - Estimated Maximum Incentive Amount</strong></th>
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<th><strong>OPTIONAL Domain 6: Children and Adult Core Measures</strong></th>
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<td>$705,124</td>
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<td>$766,439</td>
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Performing Provider:
Performing Provider name: Clarity Child Guidance Center
TPI: 112742503

Domain 1: Potentially PreventableAdmissions

Description:
Clarity Child Guidance Center is in the process of implementing electronic medical records which will greatly improve our capability to report data. Our Category 1 Project, to enhance service availability, directly links to potentially preventable admissions, a key outcome of 2.13. Improving the health of low-income populations will lead to long-term sustainable outcomes while decreasing societal burden.

The selected Category 3 measure is located within OD-2, “Potentially Preventable Admissions” and the related standalone outcome measure of 3-IT 2-4. This measure’s goal is to reduce Emergency Department visits for one of several optional target conditions, one of which is behavioral health/substance abuse. However, because this measure is available only for patients 18 and older, we were advised by HHSC to utilize the custom/optional measure of 2.13 to address that our outcomes would be related to youth, ages 3-17. Our project is of benefit to all performing providers in the region, as children are presenting in local Emergency Rooms without access to “right care, right setting” and displacing beds for treatment plans that can be addressed effectively by the local hospitals. Further, treating children when they are children prevents a host of unwelcome outcomes, including but not limited to suicide, incarceration, dropout, alcohol and drug abuse and many other societal ills.

Valuation:
The total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.

Performing Provider:
Performing Provider name: Clarity Child Guidance Center
TPI: 112742503

Domain 2: Potentially Preventable Readmissions – 30 days

Description:
Potentially Preventable Readmissions relates directly to our Category 1 project, as we seek to divert youth from presenting at Emergency Rooms with behavioral health issues for which psychiatric care is not available at said Emergency Rooms. By providing the right care in the right setting, we can provide services that lead to more effective outcomes, thereby preventing readmissions.
Valuation:
The domain valuation was based upon guidelines from HHSC that the entireties of Category 4 not exceed a certain percentage of value in the year selected. As noted in the overall valuation, the total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.

Performing Provider:
Performing Provider name: Clarity Child Guidance Center
TPI: 112742503

Domain 3: Potentially Preventable Complications

Description:
Potentially Preventable Complications measures relates directly to our Category 1 project, as we seek to divert youth from presenting at Emergency Rooms with behavioral health issues for which psychiatric care is not available at said Emergency Rooms. By providing the right care in the right setting, we can provide services that lead to more effective outcomes, thereby preventing complications. Clarity Child Guidance Center reports PPCs as part of our internal measurement system and also provides hospital provide raw discharge data to DSHS, through HCIC. In consultation with HHSC, we were advised that our data may not be statistically significant since we offer specialized services, and HHSC would report to us as a provider that we are not required to report. At reporting time, if HHSC advises us, we would note that we “lack sufficient data, as confirmed by HHSC.”

With all of this noted, research does reveal that hospital emergency rooms are the least effective method of creating a therapeutic alliance for a child/adolescent suffering from mental illness. By providing the right care in the right setting, we believe we can reduce PPCs. As an example, a local emergency room boards psychiatric patients presenting in their hospital in the NICU area, where a child who is suicidal or homicidal has access to syringes and other potentially damaging items. Our setting is safe, secure and nurturing in order to create a trusted relationship for therapeutic care.

Valuation:
The domain valuation was based upon guidelines from HHSC that the entireties of Category 4 not exceed a certain percentage of value in the year selected. As noted in the overall valuation, the total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.
Performing Provider:
Performing Provider name: Clarity Child Guidance Center
TPI: 112742503

Domain 4: Patient-Centered Healthcare

Description:
Patient-Centered Healthcare measures relates directly to our Category 1 project, as we seek to divert youth from presenting at Emergency Rooms with behavioral health issues for which psychiatric care is not available at said Emergency Rooms. By providing the right care in the right setting, we can provide services that lead to more effective outcomes, whether medication management related or patient satisfaction.

Our internally administered survey approach (based on HCAHPS) for patients who have been hospitalized benchmarks against both local and nationally respected organizations. Since we serve children ages 3-17, the caregiver/responsible party completes the survey. Clarity Child Guidance Center created the internal process several years ago, since HCAHPS does not currently make available a survey for children, which is our primary patient. HHSC has advised us to report as follows - “we will not have data to report for Cat 4 for HCAHPS as the measures currently address adult care.” However, internal data can be made available if required. HCAHPS is conducting field trials for children focused surveys and it’s possible that by DY5 HCAHPS would have measures related to our patient population, children.
We anticipate patient satisfaction and medication management to improve as a result of treatment.

Valuation:
The domain valuation was based upon guidelines from HHSC that the entireties of Category 4 not exceed a certain percentage of value in the year selected. As noted in the overall valuation, the total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.
**Performing Provider:**
Performing Provider name: Clarity Child Guidance Center  
TPI: 112742503  
**Domain 5: Emergency Department**

**Description:**
The Emergency Department measure relates directly to our Category 1 project, as we seek to divert youth from presenting at Emergency Rooms with behavioral health issues for which psychiatric care is not available at said Emergency Rooms. By providing the right care in the right setting, we can expedite care, versus the 12+ hours of “boarding time” for a psychiatric patient presenting at a local ER that has no psychiatric services. This is a measure that Clarity Child Guidance Center already has in place.

**Valuation:**
The domain valuation was based upon guidelines from HHSC that the entireties of Category 4 not exceed a certain percentage of value in the year selected. As noted in the overall valuation, the total scope of adding additional services, including a bed expansion, hiring additional providers, infrastructure updates, etc., is close to $8M in scope. Local funding is in the form of IGT funding by our affiliation partner, University Health System, who will provide $1,968,152. The 1115 Waiver will add $2,350,064 in funding for a total of $3,936,807. The remaining costs will be covered through development efforts of our nonprofit agency and self-funding through bonds. The populations that will be served are youth ages 3-17, and the community benefit is immense, not only in line with the Community Needs Analysis, but with Texas’ woeful lack of providers and access to mental healthcare.
### Category 4: Population-Focused Measures

**Clarity Child Guidance Center/112742503**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
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<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$41,467</td>
<td>$19,226</td>
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</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $19,227 $20,569 $22,356

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $19,226 $20,567 $22,356

**Domain 3: Potentially Preventable Complications (PPCs)**

- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $20,567 $22,356

**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

- **Planned Reporting Period:** 1 or 2
- **Domain 4 - Estimated Maximum Incentive Amount:** $19,226 $20,567 $22,356

**Medication Management**

- **Planned Reporting Period:** 1 or 2
- **Domain 4 - Estimated Maximum Incentive Amount:** $19,226 $20,567 $22,356
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**OPTIONAL Domain 6: Children and Adult Core Measures**

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**Grand Total Payments Across Category 4**

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<tr>
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<td>$41,467</td>
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### Performing Provider:
Performing Provider name: Connally Memorial Medical Center  
TPI: 135151206

### Domain 1: Potentially Preventable Admissions

#### Description:
As part of our Pass 2, Category 1 project Connally Memorial Medical Center is proposing to establish more primary care clinics.

Additional primary care clinics and providers will provide care for unassigned patients and will coordinate care with specialists and hospital emergency department to expand access to health services. The increased access to primary care and thus specialty services will allow patients suffering from chronic conditions such as cardiovascular disease to have local access to care. In turn, there will be better coordination between the primary care provider and specialist to prevent hospital admissions.

#### Valuation:
One of the community needs addressed in our RHP Plan is that the high prevalence of chronic disease and related health disparities require greater prevention efforts and improved management of patients with chronic conditions. Moreover, hospitalization rates are an important indicator of quality of life and patient morbidity. Patients admitted with CHF, COPD, and ESRD caused by diabetes account for the majority of hospitalizations and Medicare expenditures. Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost effective healthcare.

Additionally, the leading causes of death in Wilson county are related to cardiovascular conditions (30% of all deaths) and heart diseases (24%). This project and associated outcomes’ focus on disease management and risk reduction allows Connally Memorial Medical Center the opportunity to achieve our RHP goals of Improves outcomes while containing cost growth. This project will also help meet our goal to assure patients receive high-quality and patient-centered care in the most cost effective way.

### Performing Provider
Performing Provider name: Connally Memorial Medical Center  
TPI: 135151206

### Domain 2: Potentially Preventable Readmissions – 30 days

#### Description:
Hospital readmission rates have been proposed as an important indicator of quality of care because they may result from actions taken or omitted during the initial hospital stay. A readmission may result from incomplete treatment or poor care of the underlying problem, or may reflect poor coordination of services at the time of discharge and afterwards, such as incomplete discharge planning and/ or inadequate access to care. This is directly related to our Category 1 project of increasing access to primary care and establishing additional clinics.
**Valuation:**

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Readmission rates for the following individual medical conditions: Congestive heart failure, diabetes, COPD, stroke and asthma. All of these conditions are identified as community needs in our Regional Health plan.

**Performing Provider**

Performing Provider name: Connally Memorial Medical Center  
TPI: 135151206  
**Domain 3: Potentially Preventable Complications**

**Description:**

In Category 1, Connally Memorial Medical Center proposes to establish hospital owned and operated primary care clinics. These clinics will provide services for unassigned patients and will coordinate care with necessary specialists, and hospital emergency department to expand access to specialty and primary care services. Although, Connally Memorial Medical Center serves a population of over 40,000 residents there are limitations to our community having the full scope of primary and specialty services and thus being able to prevent certain potential complications.

As part of our goal to expand primary care capacity, CMMC hopes to provide additional services to prevent complications such as stroke and intracranial hemorrhage. By providing these services we can also work to prevent complications from congestive heart failure, acute myocardial infarction and cardiac arrhythmias.

**Valuation:**

With increasing medical care costs and a weakening economy more attention is being placed upon obtaining value from how health care dollars are spent. Initiatives to obtain increased value from health care purchases are especially focused upon perceived waste. The frequency and cost of hospital acquired complications are at the forefront of perceived waste since hospitals, patients and payers are all adversely impacted by their occurrence. While there have many advances in medicine preventable complications and conditions remain a substantial cause of morbidity and mortality among hospitalized patients.
### Domain 4: Patient-Centered Healthcare

**Description:**
An organizational strategy will be developed so that the Hospital will manage patient experience and create avenues to implement the strategic plan. Performance will be measured by the extent to which patient experience improves systematically. Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience.

The overall goal of this project is to improve how the patient experiences care and the patient’s satisfaction with the care provided.

**Valuation:**
The state healthcare transformation is counting on a robust healthcare system to improve quality as well as the patient experience. Over time, implemented projects have the potential to yield improvements in outcomes while containing cost growth, maintaining a coordinated care delivery system and ensuring patients receive high quality, patient centered care.

CMMC will implement a survey of employee experience as well as integrating the patient experience into employee training. Integrating patient experience into organizational learning is considered a best practice as it prompts staff to consider the patient experience in all parts of their day-to-day job duties.

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### Domain 5: Emergency Department

**Description:**
Connally Memorial Medical Center will measure the admit decision time to ED departure time for admitted patients. This measure is important because it measures not only the processes of care that occur while the patient is in the emergency department, but also reflects the coordination of care, communication, and efficiency of service provision beyond the walls of the emergency department. These measures also assess the prevalence of “boarding” which is the length of time a patient actually stays in the ED, after the patient has been admitted to the hospital, but before being transferred to an inpatient unit. They are more significant to patient safety and quality and a growing body of evidence has shown that boarding can increase the patient’s length of stay in the hospital and can compromise quality care. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. It also ties with other reporting domains such as creating a strategy for Patient Centered Healthcare and reducing Preventable complications. One cause of extended ED departure times results from an overcrowded ED. CMMC intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which CMMC expects will reduce the number of inappropriate ED visits.
and therefore allow for better management of ED processes such as admit decisions.

Valuation:
The value Connally Memorial Medical Center placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes and patient dissatisfaction. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. CMMC values this reporting domain at $71,333 over DY 3-5.
## Category 4: Population-Focused Measures
Connally Memorial Medical Center/135151206

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**Domain 1: Potentially Preventable Admissions (PPAs)**

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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

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**Domain 3: Potentially Preventable Complications (PPCs)**
Includes a list of 64 measures identified in the RHP Planning Protocol.

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**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

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**Medication Management**

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1625  ★  RHP 6 Plan  ★  March 8, 2013
Connally Memorial Medical Center
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<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
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<td>Domain 6 - Estimated Maximum Incentive Amount</td>
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### Performing Provider:

Provider Name: Guadalupe Regional Medical Center  
TPI: 138411709  

**Domain 1: Potentially Preventable Admissions**

**Description:**

RD1- Potentially preventable admissions (PPA) for CHF, diabetes, behavioral health and substance abuse, COPD, hypertension, pediatric asthma, and pneumonia and influenza vaccination rates relate to the following categories as outlined below:

Category 1 (1.1.2) - project I.T. 1.10 Expand Primary Care Capacity aims to improve primary care access and outcomes of the uninsured population with identified chronic illnesses. Expansion of clinic hours will provide improved healthcare access, which will reduce unnecessary emergency room visits, and admission rates for chronic illnesses. This will provide a dedicated resource for care to those in the community who are less fortunate, and provide access to medications to help the management of chronic illness.

Category 2 (2.9.1) Establish/Expand a Patient Care Navigation Program aims to establish a patient navigation system to assist high utilizers of the ED to receive coordinated, timely and appropriate healthcare services. Patient navigators will help patients and their families navigate the healthcare system and the obstacles that it entails thereby reducing PPA's.

Category 2 (2.12.2) Implement/Expand Care Transitions Program aims to promote the Triple Aim of improving the health of our population, enhancing the patient experience of care, and reducing the per capita cost of care. Through the development of a Transitional Care program, targeting patients with a primary diagnosis of CHF, COPD, DM, Pneumonia, as well as being highly sensitive to those uninsured, covered by Medicaid, or at / below the 2012 HHS poverty level, GRMC will have a positive material effect on said Triple Aim goals. GRMC has identified a gap in care transitions that create potentially preventable readmissions. Through a Transitional Care Coordinator and established policy and procedures GRMC will educate the targeted population, monitor and support through the discharge process to the home, and ensure necessary resources are referred.

Category 3 (I.T. 1.10) Expand Existing Primary Care Capacity- Diabetes Care: HbA1c poor control  
The outcome improvement target to control diabetic HbA1c levels was chosen in conjunction with our process improvement measures of expanding primary care access, clinic hours and staffing as a way to make the greatest impact on community need.  
Due to the high prevalence of uncontrolled diabetic cases in the Seguin community, it was determined that creating a system to identify patients through this newly established clinic would assist in providing care and/or management of patients diabetic A1c levels which will assist in reducing PPA's.

**Valuation:**

Our rural service area includes many low income and uninsured/under-insured individuals and families. Significantly reducing unnecessary admissions will improve the quality of life for our community as well as contribute to the continued viability of our organization and opportunities to expand services.  
The scope of the Navigation Program project should be categorized as large, due to the various coordination efforts and data collection processes that will need to be developed to manage and achieve short and long-term goals. The number of diabetic related ER visits and patient admissions...
is frequent do to the lack of primary care access for those patients who are uninsured, and unable to pay for their diabetic medications. This populations’ education level also presents challenges for long-term success and adds to the complexity of this project, because of their ability to understand the importance of their disease and their need to comply with treatment.

<table>
<thead>
<tr>
<th>Performing Provider:</th>
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<tbody>
<tr>
<td>Provider Name: Guadalupe Regional Medical Center</td>
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<tr>
<td>TPI: 138411709</td>
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<tr>
<td><strong>Domain 2: Potentially Preventable Readmissions – 30 days</strong></td>
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<tr>
<td><strong>Description:</strong></td>
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| RD2 Potentially Preventable 30 day readmissions for CHF, diabetes, behavioral health and substance abuse, COPD, stroke, and pediatric asthma relate to the following categories as outlined below:

- Category 1 (1.1.2)- project I.T. 1.10 Expand Primary Care Capacity will improve primary care access and outcomes of the uninsured population with identified chronic illnesses. Expansion of clinic hours will provide improved healthcare access, which will reduce unnecessary emergency room visits, admission and readmission rates for chronic conditions. This will provide a dedicated resource for care to those in the community who are less fortunate, and provide access to medications to help the management of chronic illness, as well as patients suffering strokes.

- Category 2 (2.9.1) Establish/Expand a Patient Care Navigation Program will establish a patient navigation system that assists high utilizers of the ED to receive coordinated, timely and appropriate healthcare services. Patient navigators will help patients and their families navigate the healthcare system and the obstacles that it entails thereby reducing PPA's and PPR’s.

- Category 2 (2.12.2) Implement/Expand Care Transitions Program will promote the Triple Aim of improving the health of our population, enhancing the patient experience of care, and reducing the per capita cost of care. Through the development of a Transitional Care program, targeting patients with a primary diagnosis of CHF, COPD, DM, Pneumonia, as well as being highly sensitive to those uninsured, covered by Medicaid, or at / below the 2012 HHS poverty level, GRMC will reduce admissions and readmissions.

- All-cause 30 day readmissions for GRMC relates to the project expanding primary care capacity, which will provide access to patient care for uninsured populations and promote disease prevention and management of chronic illnesses, specifically: diabetes. The project to implement/expand care transitions would implement improvements in transitioning patients and coordination of care from inpatient to outpatients, post-acute care, and home care settings, whereby, decreasing readmissions. Lastly, the establishment of a patient care navigation program will assist patients to manage their health issues through outpatient resources, clinics and counseling services outside of the acute care setting. Through implementation of these programs GRMC will see a reduction in 30 readmissions and unnecessary Emergency Department visits.
**Valuation:**

Acute care readmissions within 30 days of discharge create an economic and capacity hardship for the healthcare system. The Centers for Medicare and Medicaid Services (CMS) estimates the cost of avoidable readmissions at more than $17 billion each year. Additionally, such readmissions have a negative impact on the quality of life for patients and their families. The ability to coordinate care across the continuum is increasingly recognized as an indicator of the effectiveness of healthcare organizations. Adequately preparing patients for discharge and providing support during the transition process has been shown to contribute significantly to that coordination.

Our rural service area includes many low income and uninsured/under-insured individuals and families. Significantly reducing readmission rates will improve the quality of life for our community as well as contribute to the continued viability of our organization and opportunities to expand services. The Navigation Program will assist patients through outpatient resources, clinics and counseling services outside of the emergency department.

The project should be categorized as large, due to the various coordination efforts and data collection processes that will need to be developed to manage and achieve short and long-term goals. The number of diabetic related ER visits and patient admissions is frequent do to the lack of primary care access for those patients who are uninsured, and unable to pay for their diabetic medications. This populations’ education level also presents challenges for long-term success and adds to the complexity of this project, because of their ability to understand the importance of their disease and their need to comply with treatment.

The lack of diabetic resource management in the community is a real issue. By implementing and improvement target, we will help reduce the level of chronic disease currently recognized in the community, and hopefully, reduce the future rise of this illness. GRMC is currently receiving no local funding to support the management of this type of project.

**Performing Provider:**

Provider Name: Guadalupe Regional Medical Center  
TPI: 138411709  
**Domain 3: Potentially Preventable Complications**

**Description:**

RD 3 Potentially Preventable Complications:

Implementation of a transitional care program that begins assessing and educating patients at admission will assist in decreasing or avoiding potentially preventable complications of congestive heart failure and pneumonia patients.

The expansion of primary care will provide patients the resource to obtain care to prevent or improve their comorbid conditions, which will decrease the potential for preventable complications.

**Valuation:**

Guadalupe Regional Medical Center’s projects are strictly outpatient and therefore exempt from domain 3. Even though this domain will not affect the measures, GRMC will report on this domain.
Performing Provider:
Provider Name: Guadalupe Regional Medical Center
TPI: 138411709

Domain 4: Patient-Centered Healthcare

Description:
Through the implementation of GRMC's chosen category 1, 2, and 3 projects patient satisfaction will increase through improving care transitions, decreasing ED visits, condition specific education, medication education, and resource identification. The medication management measure is related to GRMC's Category 2 (2.12.2) Implement/Expand Care Transitions Program and Category 2 (2.9.1) Establish/Expand a Patient Care Navigation Program. The Transition program will improve patient medication management by providing medication education and medication reconciliation at the bedside and in their home as needed.

Valuation:
Guadalupe Regional Medical Center’s projects are strictly outpatient and therefore exempt from domain 4. Even though this domain will not affect the measures, GRMC will report on this domain.

Performing Provider:
Provider Name: Guadalupe Regional Medical Center
TPI: 138411709

Domain 5: Emergency Department

Description:
Expanding primary care project will provide for care to be provided in an office setting, which will decrease the number of ED visits. Decreasing the number of ED visits improves ED throughput by decreasing the number of unnecessary visits, which will improve admit decision time to ED departure by increasing the amount of time ED providers have to assess patients and make the decision to admit.

RD 5 Emergency department admit decision time to ED departure time for admitted patients relates to GRMC's category 3 project The Navigation Program which will assist in the management of behavior health/substance abuse patients through outpatient resources, clinics and counseling services outside of the emergency department, which will decrease the number of ED patients, allowing providers to decrease the amount of time it takes to make a decision to admit.
<table>
<thead>
<tr>
<th>Valuation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary use of the ED is a large financial hardship for the institution, especially those patients that are uninsured. The number of diabetic related ER visits and patient admissions is frequent due to the lack of primary care access for those patients who are uninsured, and unable to pay for their diabetic medications.</td>
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## Category 4: Population-Focused Measures
Guadalupe Regional Medical Center / 138411709

### Capability to Report Category 4

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td></td>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$168,128</td>
<td>$77,978</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
  - Year 2: October 1-March 31
  - Year 3: October 1-March 31
  - Year 4: October 1-March 31

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$77,978</td>
<td>$83,481</td>
<td>$90,716</td>
<td></td>
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</tbody>
</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
  - Year 2: October 1-March 31
  - Year 3: October 1-March 31
  - Year 4: October 1-March 31

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$77,978</td>
<td>$83,481</td>
<td>$90,716</td>
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</table>

### Domain 3: Potentially Preventable Complications (PPCs)

- Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td></td>
<td>$83,481</td>
<td>$90,716</td>
<td></td>
</tr>
</tbody>
</table>

### Domain 4: Patient Centered Healthcare

- **Patient Satisfaction - HCAHPS**
  - Measurement period for report: 10/1/2012 - 9/30/2013
  - Planned Reporting Period: 1 or 2
    - Year 2: April 1 - Sept. 30
    - Year 3: April 1 - Sept. 30
    - Year 4: April 1 - Sept. 30
    - Year 5: April 1 - Sept. 30

### Medication Management

1632 ★ RHP 6 Plan ★ March 8, 2013  Guadalupe Regional Medical Center
### Domain 4: Estimated Maximum Incentive Amount

<table>
<thead>
<tr>
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<tr>
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<td>2: April 1- Sept. 30</td>
<td>2: April 1- Sept. 30</td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$77,978</td>
<td>$83,481</td>
<td>$90,716</td>
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</table>

### Domain 5: Emergency Department

<table>
<thead>
<tr>
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</thead>
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<tr>
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<td>2: April 1- Sept. 30</td>
<td>2: April 1- Sept. 30</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$77,978</td>
<td>$83,481</td>
<td>$90,716</td>
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</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

| Domain 6 - Estimated Maximum Incentive Amount | $0 | $0 | $0 |

### Grand Total Payments Across Category 4

<p>| $168,128 | $389,890 | $417,405 | $453,580 |</p>
<table>
<thead>
<tr>
<th>Performing Provider:</th>
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</thead>
<tbody>
<tr>
<td>Performing Provider name: Hill Country Memorial Hospital</td>
</tr>
<tr>
<td>TPI: 136430906</td>
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</table>

**Domain 1: Potentially Preventable Admissions**

**Description:**
With the introduction of widespread preventive care screening in our community through project 136430906.2.1, it is very likely that, in the short-term and the long-term, uninsured patients with ambulatory care sensitive conditions will be less frequent visitors to both the emergency room and then to inpatient units. Since we will be testing for diabetes, hypertension, colorectal cancer, cervical cancer, obesity, hypertension, and many other conditions in project 136430906.2.1, we will be identifying cases of chronic disease in earlier stages than they would have otherwise been found. If these conditions are caught early in the disease process, then care can be received in an appropriate setting rather than inpatient admissions becoming necessary. Secondary preventive interventions can be initiated and the patients can begin to receive care in the appropriate outpatient setting. If the conditions are not screened for and noted early, patients are more likely to end up in the emergency or inpatient setting in either more critical condition or because they have no medical home. We anticipate that the number of uninsured individuals with potentially preventable admissions will decrease by at least 5% by the end of DY5. A decrease of this size would be a cost savings to the community of at least $500,000 based on average costs of chronic disease care for the target population size.

**Valuation:**
The National Quality Forum identifies the value of measuring potentially preventable admissions as: “A significant portion of all costs incurred by patients and payers in today’s healthcare system is due to “care defects” – errors, avoidable hospitalizations, and other process failures that cause patients to incur unnecessary services and some harm. For example, a recent report by the Agency of Health Care Research and Quality (AHRQ) highlighted that, in 2006, 4.4 million out of 39 million (11%) hospital stays could have been prevented (amounting to $30.8 billion of hospital costs), and one in five admissions for Medicare beneficiaries were for a potentially preventable condition. To improve accountability in the delivery of chronic care, AHRQ has developed a list of prevention quality indicators (PQIs) to identify ambulatory care sensitive conditions (ACSCs) and to measure rates of admissions that could have been potentially avoided with good outpatient care. While most of these studies (and their associated metrics) focus on a condition, our approach has been to focus on the patient and include all potentially avoidable complications that impact that patient. The core principle is to develop a patient-centered metric that creates accountability for all physicians that manage and co-manage the patient – whether they co-manage consciously or not. While cardiologists may feel that they should only be responsible for PACs related to a patient’s diabetes or lung disease, we consider that a patient’s cardiologist, internist, pulmonologist and any other physician should be jointly accountable for the management of the patient’s CHF, Diabetes and Asthma, and that any PAC related to any of these co-morbid conditions would be counted as such and tagged to each physician. It is only by creating accountability in this fashion that we can hope to encourage the true coordination of care and the development of systems of care centered around the patient” (NATIONAL QUALITY FORUM, National Voluntary Consensus Standards for Patient Outcomes, Measure, Summary Measure Number: OT2-022-09, Measure Name: Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year). Systems will need to be developed to ensure we are appropriately capturing this key data, especially during the transition to ICD 10 coding. So, in addition to the funding requested for this category,
Performing Provider:
Performing Provider name: Hill Country Memorial Hospital
TPI: 136430906
Domain 2: Potentially Preventable Readmissions
Description:
Though preventive care screenings (project 136430906.2.1) that this performing provider has selected for Categories 2 and 3 are not interventions that directly impact readmissions, it is anticipated that the overall health of the community will improve through the program. Patients who do not enter the hospital with a chronic condition in the first place because it is being managed appropriately in a medical home, will not have readmissions for conditions that are preventable with this kind of care. Though our readmission rate is already at benchmark performance levels of 5-6% for all cause, 30 day readmissions, we believe that we may see a decrease in this number as well over the next several years as the health of the uninsured community improves. Even a slight decrease in readmissions has a major impact on cost to the community.
Valuation:
The Centers for Medicaid and Medicare Services have reported the value of readmission reduction: Beyond improving the quality of care for Medicare beneficiaries with chronic conditions—who comprise over 80 percent of all Medicare enrollees—the CMS Office of the Actuary (OAct) projects that this provision, when fully implemented, will reduce Medicare costs by $8.2 billion from implementation through 2019 (ACA Update, Implementing Medicare Cost Savings). The June 2007 MedPAC report to Congress on “Promoting Greater Efficiency in Medicare” highlighted that, in 2005, $12 billion were spent on potentially preventable readmissions alone within 30 days of discharge from the hospital. Another study by Jencks and colleagues found that roughly 19.6% of Medicare patients incurred re-hospitalizations within 30 days of discharge. When hospitalizations do occur, they must be managed expeditiously and readmissions following discharge should be avoided. Readmissions after admissions for chronic conditions such as readmissions after heart failure hospitalizations form a subset of our PAs. Some studies have reported readmission rates after heart failure discharge as high as 45% at 6 months (NATIONAL QUALITY FORUM, National Voluntary Consensus Standards for Patient Outcomes, Measure, Summary Measure Number: OT2-022-09, Measure Name: Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year). A study of Texas Medicaid readmissions found that the most common reasons for readmission, in roughly equal proportions, are medical readmissions for the same condition, medical readmissions for other acute conditions, and readmissions for mental illness or substance abuse (Texas Health and Human Services Commission, Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2009). Hill Country Memorial Hospital will be providing an estimated additional $50,000 in staff time and technical systems to support this metric.
Performing Provider:
Performing Provider name: Hill Country Memorial Hospital
TPI: 136430906

**Domain 3: Potentially Preventable Complications**

**Description:**
Though it is not directly related to the Category 2 project (Project 136430906.2.1) that we have submitted, the outcomes in this measure set are relevant to several projects in our region. Through our learning collaboratives, we look forward to learning best practices from other providers in our region to improve our care and decrease our rate of complications. Potentially preventable complications are a key focus of Hill Country Memorial Hospital, and we anticipate that the numbers of these events should decrease by at least 5% over the next for years. We have a number of teams and initiatives in place to address the complication rates at the hospital, especially surgical site infections, venous thromboembolism, and birth injuries. Preventing even one additional complication is a cost savings of around $10,000.

**Valuation:**
High complication rates, after adjusting for patient characteristics and severity of illness, indicate low-quality care, waste, and, therefore, potential cost savings. In fact, the estimated incremental increase in cost per potentially preventable complication is approximately $10,000. So for every complication that’s eliminated, $10,000 on average is saved and profit margin improves. According to the study, savings generated by many of our national improvement priorities can be substantial. For each catheter-related bloodstream infection avoided, savings average $18,000 to $22,000 per case. For every decubitus ulcer avoided, $17,500 to $28,000 is saved. Postoperative infections with deep wound disruption costs an additional $14,400, and venous thrombosis costs approximately $11,000 to $16,000. The implications for our hospitals are staggering. Potentially preventable complications add approximately 9.5 percent to our inpatient costs, or $88 billion per year to our national healthcare expense, according to the study. (Fuller, R. L., McCullough, E. C., Bao, M. Z., and others, “Estimating the Costs of Potentially Preventable Hospital Acquired Complications,” Health Care Financing Review, Summer 2009, pp. 17-32)

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Performing Provider:
Performing Provider name: Hill Country Memorial Hospital
TPI: 136430906

**Domain 4: Patient-Centered Healthcare**

**Description:**
Though it is not directly related to the Category 2 project (project 136430906.2.1) that we have submitted, several projects in our region are focused on improving the patient experience. Through our learning collaboratives, we look forward to learning best practices from other providers in our region to improve the patient experience for our customers as well. Our goal is to be in the 95th percentile on every HCAHPS and Press Ganey indicator of patient satisfaction and engagement. The majority of our metrics do fall at or close to this goal. Those that fall short are being aggressively addressed through strategic objectives. Therefore, we anticipate that our performance on all four these indicators will improve to at least 95th percentile by the end of the fifth demonstration year. An improvement in the patient experience assures that our community is receiving better value care.
Valuation:
The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced "H-caps"), also known as the CAHPS® Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare & Medicaid Services (CMS) and the HCAHPS Project Team have taken substantial steps to assure that the survey is credible, useful, and practical. (Centers for Medicare & Medicaid Services (CMS). CAHPS® Hospital Survey (HCAHPS). Quality assurance guidelines. Version 7.0. Baltimore (MD): Centers for Medicare & Medicaid Services (CMS); 2012 Mar. p. 586) Hill Country Memorial Hospital will be providing an estimated additional $50,000 in staff time and technical systems to support this metric.

Performing Provider:
Performing Provider name: Hill Country Memorial Hospital
TPI: 136430906
Domain 5: Emergency Department
Description:
This is not something that is currently systematically measured at Hill Country Memorial Hospital, so beginning to measure and set targets for improvement will have significant positive impact on our ability to see patients quickly and move them to the appropriate level of care. Though it is not directly related to the Category 2 (Project 136430906.2.1) or 3 projects that we have submitted, it is similar to several projects in our region. Through our learning collaboratives, we look forward to learning best practices from other providers in our region to improve our care and ED efficiency.

Valuation:
Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90% of large hospitals report EDs operating "at" or "over" capacity. Approximately one third of hospitals in the U.S. report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40% of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency
For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised (Specifications manual for national hospital inpatient quality measures, version 3.1a. Centers for Medicare & Medicaid Services (CMS), The Joint Commission; 2010 Apr 1. various p.). Hill Country Memorial Hospital will be providing an estimated additional $50,000 in staff time and technical systems to support this metric.
### Category 4: Population-Focused Measures

**Hill Country Memorial Hospital / 136430906**

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Capability to Report Category 4</strong></td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$37,771</td>
<td>$17,512</td>
<td></td>
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</tr>
</tbody>
</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

- Planned Reporting Period: 1 or 2
- Domain 1 - Estimated Maximum Incentive Amount $17,512

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

- Planned Reporting Period: 1 or 2
- Domain 2 - Estimated Maximum Incentive Amount $17,513

**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

- Planned Reporting Period: 1 or 2
- Domain 3 - Estimated Maximum Incentive Amount $18,734

**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**
- Planned Reporting Period: 1 or 2
- Measurement period for report Calendar Year

**Medication Management**
- Planned Reporting Period: 1 or 2
- Measurement period for report Calendar Year

**Domain 4 - Estimated Maximum Incentive Amount** $17,513
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<tr>
<th><strong>Domain 5: Emergency Department</strong></th>
<th>Calendar Year</th>
<th>Calendar Year</th>
<th>Calendar Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement period for report</td>
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<td></td>
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<tr>
<td>Planned Reporting Period: 1 or 2</td>
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<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$17,513</td>
<td>$18,735</td>
<td>$20,364</td>
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</table>

**OPTIONAL** Domain 6: Children and Adult Core Measures

| Domain 6 - Estimated Maximum Incentive Amount | $0 | $0 | $0 |

| **Grand Total Payments Across Category 4** | $37,771 | $87,563 | $93,672 | $101,818 |
### Domain 1: Potentially Preventable Admissions

#### Description:

**Reporting Measures:**

1. Congestive Heart Failure Admission rate
2. Diabetes Admission Rates (i. Exempt)
3. Behavioral Health and Substance Abuse Admission rate
4. Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission rate
5. Hypertension Admission rate
6. Pediatric Asthma
7. Bacterial pneumonia immunization
8. Influenza Immunization

*Note: Exempt domains will be determined during reporting period.*

For the diagnoses with a denominator of residents > 18 years old living in RHP counties (CHF, uncontrolled diabetes, diabetes long term complications, COPD, HTN,) we will use our EHR (electronic health record) to determine the numerator value of patients discharged. We do not qualify for metrics involving RHP primary clinics such as the diabetic short term complication denominator (2. i. Diabetes, short term complications (derived from AHRQ PQI #1). For behavioral health and substance abuse admission rate, we will use our EHR to determine the patients and rates. For pediatric asthma, we will track ED visits by our ED EHR. Once these rates and patients are identified, we can target selected patients and patients living in selected zip codes within the RHP counties to admit at risk patients to our navigator programs through hospital based navigators (CHF) and home care partners (all others) to coordinate a Medical Home and appropriate outpatient care to reduce potentially avoidable admissions. We expect to improve preventable admissions in DYs 2-5 by using these reporting requirements and making improvements to clinical care. We will continue our current physician-approved management protocols, tracking and reporting for Bacterial Pneumonia and Influenza Immunization rates in hospitalized patients.

Relates to Category 1,2,3:

- Implement telemedicine program to provide or expand specialists referral services in an area identified as needed to the region (1.7.1) and improve access to Care- Increase number of ED locations (1.9.2): Methodist plans to implement projects that will expand care to areas identified as needed in the region. In doing so, Methodist will increase access to much needed care, which will result in a decrease preventable admissions.

#### Valuation:

Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which Potentially Preventable...
Admissions reporting would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

<table>
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<td>Domain 2: Potentially Preventable Readmissions – 30 days</td>
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<td>REPORTING MEASURES:</td>
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<tr>
<td>- Congestive Heart Failure (HF): 30 Day Readmissions</td>
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<td>- Diabetes: 30-Day Readmissions</td>
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<td>- Behavioral health &amp; Substance Abuse: 30-Day Readmissions</td>
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<td>- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions</td>
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<td>- Stroke: 30-Day Readmissions</td>
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<td>- Pediatric Asthma: 30-Day Readmissions</td>
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<td>- All–Cause: 30-Day Readmissions</td>
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<td>Exempt domain(s): To Be Determined</td>
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<tr>
<td>Expected Improvement(s): to decrease readmissions</td>
</tr>
</tbody>
</table>

- Within a 30-day time frame, readmissions are more likely attributable to care received during the index hospitalization and during the transition to the outpatient setting. A number of studies have demonstrated that improvements in care at the time of patient discharge can reduce 30-day readmission rates.\(^{19,20,22,27-34,38}\) Hospitals, in collaboration with their medical communities, can take a number of actions to reduce readmissions: ensure patients are clinically ready at discharge; reduce risk of infection; reconcile medications; improve communications among providers involved in transition of care; encourage strategies that promote disease management principles; and educate patients about symptoms to monitor, whom to contact with questions, and where and when to seek follow-up care.\(^{19,20,22,27-34,38}\) Studies also show that it can take more than 14 days for the benefits of these interventions to appear.\(^{39}\) (source: National Quality Forum Measure Submission and Evaluation Worksheet 5.0)

- 30-day timeframe is consistent with the other CMS readmission measures approved by the National Quality Forum (NQF) and publicly reported by CMS.

- Factors most relevant to readmission risk:
  - medication reconciliation
  - patient education
  - post- discharge follow up
  - communication with outpatient clinicians

- How this relates to categories 1, 2 & 3
  - As addressed in category 1, expanding Telemedicine/Telehealth programs for patients, so they may be able to access specialty care programs, and expanding specialty care capacity in the emergency departments, may assist in reducing readmissions.
As addressed in categories 2 & 3, improving patient experience may help in reducing readmissions as the following areas can directly reduce readmission rates: quality of care during the initial admission; improvement in communication with patients, their caregivers and their clinicians; patient education; predischarge assessment; and coordination of care after discharge.

**Valuation:**

Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which Potentially Preventable Readmissions reporting would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

**DOMAIN 2 References:**


---

**Performing Provider:**

Performing Provider name: Methodist Hospital  
TPI: 094154402

**Domain 3: Potentially Preventable Complications**

**Description:**

Reporting Measure: Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed in Domain 3 in DY 4-5.

MHS has a system reporting potentially avoidable complication with a focus on AHRQ Patient Safety Indicator software since 2009. This has allowed us to identify and track many of these complications that have been identified as AHRQ PSIs. We have developed specific procedures and protocols to reduce those that were above national rates such as pressure sores, falls, central line associated blood steam infections, etc. We have also been able to participate in several improvement projects through MHS hospital network. There are additional complications listed in this project that we have not been tracking. The funding from this project will allow us to include these additional complications and apply our demonstrated performance improvement methodologies to reduce these complications. This will require an attentive focus from our Quality Improvement and Patient Care teams. We expect to improve potentially preventable complications in DY’s 2-5 by using these reporting measures and adjusting clinical care as necessary.

Relates to Category 1,2,3:

- Implement telemedicine program to provide or expand specialists referral services in an area identified as needed to the region (1.7.1) and improve access to Care- Increase number of specialty ED locations (1.9.2): Methodist plans to implement projects that will expand care to areas identified as needed in the region. In doing so, Methodist will increase access to much needed care, which will result in a reduce preventable complications.
- Redesign to Improve Patient Experience (2.4.2) and (3 IT 6.1)- Percent Improvement over baseline of patient satisfaction scores: Methodist plans to implement projects to improve the patient experience. This will include follow-up with patients to reduce/track preventable complications.
Valuation:
Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which Potentially Preventable Complications reporting would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

<table>
<thead>
<tr>
<th>Performing Provider:</th>
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</thead>
<tbody>
<tr>
<td>Performing Provider name: Methodist Hospital</td>
</tr>
<tr>
<td>TPI: 094154402</td>
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</tbody>
</table>

**Domain 4: Patient-Centered Healthcare**

**Description:**

- **Reporting Measures:**
  - Patient Satisfaction
  - Medication management

Our Care measures across the entire MHS are divided into 5 areas: Care process, outcomes, efficiency, safety and experience. The patient experience scores are shared in this format at every medical specialty and medical executive meeting, every nursing care unit meeting and at every board meeting. We expect to improve patient satisfaction in DYs 2-5 by improving clinical teamwork which leads to improved patient experience of care.

In Medication Management, we are critically analyzing medications at every level of transition: admission, change to OR or nursing unit, and discharge. We have an electronic hospital information record that enhances this medication reconciliation process to improve safety. We expect to improve medication management in DYs 2-5 by improving the medication reconciliation process with help from our electronic systems that flag significant drug interactions.

Relates to Category 1,2,3:

- Redesign to Improve Patient Experience (2.4.2) and (3 IT 6.1)- Percent Improvement over baseline of patient satisfaction scores: Methodist plans to implement projects to improve the patient experience. Improvement in communication with patients, their caregivers and their clinicians; patient education; predischarge assessment; and coordination of care after discharge.
Valuation:
Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which **Patient-Centered Healthcare** reporting would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

Performing Provider:
Performing Provider name: Methodist Hospital
TPI: 094154402
**Domain 5: Emergency Department**

Description:
Reporting Measures:

- Admit decision to departure time for admitted patients

We expect to improve Emergency Department decision time to transfer an emergency patient to another facility.

Relates to Category 1,2,3:

- Improve access to Emergency Care- Increase ED locations (1.9.2): Methodist plans to implement projects that will expand Emergency Department care to areas identified as needed in the region. In doing so, Methodist will increase access to much needed care, this will enable MHS to track decision time to transfer an emergency patient to another facility.

Valuation:
Methodist values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing the project, Methodist took into account the extent to which **Emergency Department** reporting would potentially meet the goals of the Waiver (improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
### Category 4: Population-Focused Measures

**METHODIST HOSPITAL - 094154402**

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<tr>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
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<td>$568,648</td>
<td>$263,655</td>
<td>$282,050</td>
<td>$306,576</td>
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**Domain 1: Potentially Preventable Admissions (PPAs)**

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<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>1: October 1 – March 31</td>
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<td>Domain 1 - Estimated Maximum Incentive Amount</td>
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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

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**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td>Domain 4: Patient Centered Healthcare</td>
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<tr>
<td><strong>Patient Satisfaction – HCAHPS</strong></td>
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<td><strong>Domain 5: Emergency Department</strong></td>
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### Performing Provider:

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<tr>
<th>Provider Name</th>
<th>Nix Health Care System</th>
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<tbody>
<tr>
<td>TPI</td>
<td>297342201 <em>(old TPI 112676501)</em></td>
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</table>

### Domain 1: Potentially Preventable Admissions

#### Description:

*How does this Category 4 measure relate to other Category 1, 2, or 3 projects?*

Category 2.1 – Medical Homes: patients’ chronic conditions will be better managed by the physician-led care team and steps will be taken to proactively avoid hospitalizations.

Category 3.12 – Pneumonia Vaccinations, Colon Cancer Screening, and Breast Cancer Screening: through preventive screening and vaccinations, the Medical Home patients will be at reduced risk for admission.

Category 2.8 - Performance Improvement Initiative related to Geriatric Patients: the patients’ entire health will be considered and addressed during hospitalization rather than focusing solely on the acute illness requiring admission. This will reduce readmissions as well as address issues that may be the cause of subsequent admissions further in the future.

Category 2.9 – Patient Navigator Program: patients that are at high risk for admission will be identified and referred to the program and staff will work directly with the patient and their family/care givers to take proactive steps in managing their health which should result in fewer hospital admissions.

*Describe the expected improvements in each Category 4 domain for DYs 2-5.*

We expect to see a decrease in all of the Potentially Preventable Admissions for these illnesses:

- Congestive Heart Failure
- Diabetes Admission Rates
  - Diabetes short-term complications
  - Uncontrolled Diabetes
  - Diabetes long-term complications Admission Rate
- Behavioral Health/Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission Rate
- Bacterial Pneumonia Vaccination
- Influenza related-admissions

We do not expect to see a change in Pediatric Asthma since we do not admit pediatric med/surg patients

*Is this domain measure exempt? If so, why?*

No, this domain measure is not exempt

#### Valuation:

Nix Health is participating in the required 5 Category 4 Domains, but not in the Optional 6th Domain. Therefore, our Category 4 funding is 5% of our total DSRIP funding in DY2 and 10% in DY3-DY5. Per the Program Funding and Mechanics Protocol, milestones within a demonstration year for Category 4 shall be valued equally, so this domain will be valued at 1% of our total DSRIP funding for DY2 and 2% of our total DSRIP funding for DY3-DY5.
It is reasonable to value this project as $451,380 over the remaining 4 years of this waiver because reporting on the Potentially Preventable Admissions will help us identify ways that we can better work with our physicians, especially through our Patient Navigator Program, to educate patients on self-management of chronic diseases and identify community and health care resources that are available to patients so they can proactively manage their conditions and avoid potentially preventable hospitalizations.

**Performing Provider:**
Provider Name: Nix Health Care System  
TPI: 297342201 *(old TPI 112676501)*

**Domain 2: Potentially Preventable Readmissions – 30 days**

**Description:**

*How does this Category 4 measure relate to other Category 1, 2, or 3 projects?*

Category 2.1 – Medical Homes: after discharge, contact will be made with Medical Home patients to ensure they understand their post-discharge instructions and have any of their questions answered and this will impact readmission rates.

Category 3.12 – Pneumonia Vaccinations, Colon Cancer Screening, and Breast Cancer Screening: through preventive screening and vaccinations, the Medical Home patients will be at reduced risk for readmission.

Category 2.8 - Performance Improvement Initiative related to Geriatric Patients: we will be implementing evidence-based measures to improve quality and outcomes which will directly impact readmission rates.

Category 3.3 – All-Cause 30-day Readmissions: As a Category 3 measure for our Category 2.8 project, we will be monitoring the 30-day readmission rates for the particular patient population.

Category 2.9 – Patient Navigator Program: patients that are at high risk for readmission will be identified and referred to the program and staff will work directly with the patient and their family/care givers to take proactive steps in managing their health which should result in fewer hospital admissions.

**Describe the expected improvements in each Category 4 domain for DYs 2-5.**

We expect to see a decrease in all of the 30-day readmissions for these illnesses:

- Congestive Heart Failure
- Diabetes
- Behavioral Health & Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Stroke
- All Cause

We do not expect to see a change in Pediatric Asthma readmissions since we do not admit pediatric med/surg patients.
**Is this domain measure exempt? If so, why?**

No, this domain measure is not exempt

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**Valuation:**

Nix Health is participating in the required 5 Category 4 Domains, but not in the Optional 6th Domain. Therefore, our Category 4 funding is 5% of our total DSRIP funding in DY2 and 10% in DY3-DY5. Per the Program Funding and Mechanics Protocol, milestones within a demonstration year for Category 4 shall be valued equally, so this domain will be valued at 1% of our total DSRIP funding for DY2 and 2% of our total DSRIP funding for DY3-DY5.

It is reasonable to value this project as $451,380 over the remaining 4 years of this waiver because reporting on the Potentially Preventable Readmissions will help us identify ways that we can better work with our physicians and be more actively engaged with patients post-discharge to answer any questions they have, ensure they are following their discharge instructions and taking their medications as prescribed. As we identify trends in potentially preventable readmissions, we can implement evidence-based approaches to minimize these readmissions.

---

**Performing Provider:**

Provider Name: Nix Health Care System  
TPI: 297342201 *(old TPI 112676501)*

**Domain 3: Potentially Preventable Complications**

**Description:**

*How does this Category 4 measure relate to other Category 1, 2, or 3 projects?*

Category 3.12 – Pneumonia Vaccinations: Vaccinating patients proactively for pneumonia will help avoid PPCs

Category 2.8 - Performance Improvement Initiative related to Geriatric Patients: PI projects that we implement will be aimed at reducing pressure ulcers, and minimizing fall risks to reduce in-hospital trauma and fractures

**Describe the expected improvements in each Category 4 domain for DYs 2-5.**

We will take measures to improve our rates of Potentially Preventable Complications throughout the system, but we specifically expect to see improvements in these PPCs given our Category 1, 2 and 3 projects outlined above:

- Pneumonia and Other Lung Infections
- In-Hospital Trauma and Fractures
- Decubitus Ulcer

**Is this domain measure exempt? If so, why?**

No, this domain measure is not exempt
Valuation:

Nix Health is participating in the required 5 Category 4 Domains, but not in the Optional 6th Domain. Therefore, our Category 4 funding is 5% of our total DSRIP funding in DY2 and 10% in DY3-DY5. Per the Program Funding and Mechanics Protocol, milestones within a demonstration year for Category 4 shall be valued equally, so this domain will be valued at 1% of our total DSRIP funding for DY2 and 2% of our total DSRIP funding for DY3-DY5.

It is reasonable to value this project as $311,803 over the remaining 4 years of this waiver because reporting on the Potentially Preventable Complications will help us identify areas of improvement and take necessary steps for improving our complication rates and overall outcomes.

Performing Provider:

Provider Name: Nix Health Care System
TPI: 297342201 (old TPI 112676501)

Domain 4: Patient-Centered Healthcare

Description:

How does this Category 4 measure relate to other Category 1, 2, or 3 projects? Category 2.1 – Medical Homes: relationships between patients and physicians/care teams will be improved through the medical home model which will improve patient satisfaction. Since these physicians will attend on their patients when admitted, inpatient satisfaction scores will be impacted as well.

Category 2.8 - Performance Improvement Initiative related to Geriatric Patients: the evidence-based initiatives we will be implementing will directly affect patient satisfaction scores.

Describe the expected improvements in each Category 4 domain for DYs 2-5.

We expect inpatient medication management and patient satisfaction scores to improve.

Is this domain measure exempt? If so, why? No, this domain measure is not exempt

Valuation:

Nix Health is participating in the required 5 Category 4 Domains, but not in the Optional 6th Domain. Therefore, our Category 4 funding is 5% of our total DSRIP funding in DY2 and 10% in DY3-DY5. Per the Program Funding and Mechanics Protocol, milestones within a demonstration year for Category 4 shall be valued equally, so this domain will be valued at 1% of our total DSRIP funding for DY2 and 2% of our total DSRIP funding for DY3-DY5.

It is reasonable to value this project as $451,380 over the remaining 4 years of this waiver because reporting on the Inpatient Medication Management and Patient Satisfaction Scores gives us valuable insight into the patient’s experience and communication gaps that may exist in our system. By understanding and examining these gaps, we can take steps to improve these patient experience targets.
### Performing Provider:

Provider Name: Nix Health Care System  
TPI: 297342201 (old TPI 112676501)  
**Domain 5: Emergency Department**

### Description:

**How does this Category 4 measure relate to other Category 1, 2, or 3 projects?**

Category 2.9 – Patient Navigator Program: patients that are high ED utilizers, or those who utilize the ED for episodic care will be identified and enrolled in the patient navigator program which will reduce the ED traffic and allow for improved ED throughput and shorter Admission-Decision times.

Category 2.1 – Medical Homes: patients who receive care through a Medical Home will be less likely to seek treatment through the ED for care that can be managed through their Medical Home, which will help reduce unnecessary utilization of the ED and allow for improved ED throughput and shorter Admission-Decision times.

**Describe the expected improvements in each Category 4 domain for DYs 2-5.**

Our ED is opening in late 2012, and we expect to have an accurate baseline established by the end of DY3. From that baseline, we expect to see an improvement in the Admission-Decision times due to improved processes, as well as by better managing the high ED utilizers and connecting them with routine primary care.

**Is this domain measure exempt? If so, why?**

No, this domain measure is not exempt.

### Valuation:

Nix Health is participating in the required 5 Category 4 Domains, but not in the Optional 6th Domain. Therefore, our Category 4 funding is 5% of our total DSRIP funding in DY2 and 10% in DY3-DY5. Per the Program Funding and Mechanics Protocol, milestones within a demonstration year for Category 4 shall be valued equally, so this domain will be valued at 1% of our total DSRIP funding for DY2 and 2% of our total DSRIP funding for DY3-DY5.

It is reasonable to value this project as $451,380 over the remaining 4 years of this waiver because reporting on the Admission-Decision Time in the ED gives us valuable insight into the throughput and efficiency of our emergency department. By understanding and examining these trends in these times, we can take steps to improve these metrics.
### Category 4: Population-Focused Measures  
*Nix Health Care System / 297342201 (old TPI 112676501)*

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<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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**Estimated Maximum Incentive Amount**: $300,939

$139,576

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<tr>
<th>Domain 1: Potentially Preventable Admissions (PPAs)</th>
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<tr>
<td><strong>Planned Reporting Period:</strong> 1 or 2</td>
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<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
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<tr>
<th>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</th>
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<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
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<tr>
<th>Domain 3: Potentially Preventable Complications (PPCs)</th>
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<tr>
<td><strong>Planned Reporting Period:</strong> 1 or 2</td>
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<td>Domain 3 - Estimated Maximum Incentive Amount</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<tr>
<th>Domain 4: Patient Centered Healthcare</th>
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<tbody>
<tr>
<td><strong>Patient Satisfaction - HCAHPS</strong></td>
</tr>
<tr>
<td>Measurement period for report</td>
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<tr>
<td>Planned Reporting Period: 1 or 2</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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| **Medication Management** |
| Measurement period for report |
| Planned Reporting Period: 1 or 2 |
| Year 2 (10/1/2012 – 9/30/2013) | 2 (4/1-9/30) | 2 (4/1-9/30) |
| Year 3 (10/1/2013 – 9/30/2014) | 7/1-6/30 | 7/1-6/30 |
| Year 4 (10/1/2014 – 9/30/2015) | 7/1-6/30 | 7/1-6/30 |

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<td>Domain 5: Emergency Department</td>
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**OPTIONAL** Domain 6: Children and Adult Core Measures

| Domain 6 - Estimated Maximum Incentive Amount | $ N/A | $ N/A | $ N/A |

| Grand Total Payments Across Category 4 | $300,939 | $697,881 | $747,129 | $811,888 |
Domain 1: Potentially Preventable Admissions

Description:

Potentially preventable hospitalizations—inpatient stays that might be avoided with the delivery of high quality outpatient treatment and disease management—serve as useful indicators of possible unmet community health needs. By measuring the frequency of these types of hospitalizations among patient subpopulations, PRMC and its providers can identify those areas most in need of improvements in discharge teaching and education as well as post-hospitalization follow-up from the discharge advocate (DA). Rates of potentially preventable hospitalizations are higher for vulnerable populations with limited access to care. During the patients hospitalization the DA can target issues in access to primary care that may serve to narrow disparities in health outcomes and improve the quality of care while reducing costs.

Hospitalizations for diabetes complications are generally considered preventable with high-quality health care and patient adherence to treatment. Clinical studies suggest that prevention activities, quality outpatient care, and greater patient self-management of diabetes may prevent or reduce the prevalence of cardiovascular disease, lower extremity amputations, and multiple hospitalizations associated with diabetes. Patient self-management—taking medications appropriately, controlling blood sugar levels, and managing diet with regular exercise—are important components an important component of the DA’s patient education of diabetes care. With appropriate primary care for diabetes complications, nearly $2.5 billion in hospital costs might have been averted, with significant potential savings obtained in Medicare ($1.3 billion of total costs) and Medicaid ($386 million of total costs).

PRMC’s Health care/system redesign involves making systematic changes to chronic care management, transition of care, and patient discharge planning to improve the quality, efficiency, and effectiveness of patient care. Frameworks, models, and concepts such as the Chronic Care Model and the evidence based care transition/discharge model, Patient Re-Engineered Discharge (Project RED), can be used together to reorganize care delivery for the purpose of improving patient outcomes.

The redesign of these practices includes the following:

- Adopting strategies for transforming our practice to improve quality, reduce costs, and better satisfy the needs of patients and families.
- Include preventive services and self-management support into patient care and discharge teaching.
- Empowering all clinic staff to suggest and help implement effective changes.
- Develop leadership for change and ongoing quality improvement.
- Involvement of the DA, Chronic Disease Educator, and the Care Coordination Department to help with the process of health care redesign

Diabetes is one chronic condition whose treatment and outcomes are heavily dependent on how well the patient monitors and manages the disease outside the health care setting. An important approach to quality improvement for diabetes is improving patient self-management. Project RED will emphasize and focus on patient education and behavior modification. The DA will work with patients to build their confidence in managing their own disease, in working within the health care system and the community to have their needs met, and in managing the emotional effects of their illness prior to being discharged from the hospital. Patients are
informed about their disease and trained using evidence-based information in how they should manage their condition. Thus, the DA using the discharge model, Project RED, emphasizes a collaborative approach among health care teams to develop new and better clinical procedures and systems that support providers and patients in treating and managing chronic illness over time.

When patients that are considered high risk for a preventable admission come into the hospital, the triage nurse can alert the emergency department case manager or if available, the DA whom discharged the patient during their last hospital admission. Patients who meet criteria for an intervention include patients who were discharged from the hospital in the past 30 days, or have had five emergency department visits in the last year, those who are homeless, living in a shelter, or who have tenuous housing situations. These “patient navigators” can meet with the patient before he or she is evaluated by the physician. They work with the physician to determine an alternative to hospitalization by arranging services in the community. We will emphasize to the emergency department staff and physicians that we are not telling them not to admit patients if they need it, but that we are working with them to provide resources to prevent an unnecessary admissions if reasonable.

Some admissions are not preventative because patients have complex medical conditions that require a hospital stay, but by having case managers in the emergency department and the discharge advocates collaborating with the clinicians and providing feedback to the people who take care of the person at home and/or in the outpatient setting (home health, primary care provider, etc.), we can establish continuity in care across settings and into the community. This program will play a significant role in changing the mindset of the emergency department team. It will give them the confidence and comfort level to discharge people back to the community when resources are in place and available for the patients use. Changes in these potentially preventable admission rates over time should signal an improvement in the quality of our ambulatory care environment, patient access to timely and effective treatment, or in patient adoption of healthy behaviors.

**Valuation:**

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<tr>
<th>Performing Provider</th>
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<tr>
<td>Provider name: Peterson Regional Medical Center</td>
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<tr>
<td>TPI: 127294003</td>
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<tr>
<td><strong>Domain 2: Potentially Preventable Readmissions – 30 days</strong></td>
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<tr>
<td><strong>Description:</strong></td>
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<td>Hospital readmissions are an important measure for assessing performance of the health care system. One strategy for improving health care quality and lowering costs is to reduce the rates of preventable readmissions. Health care costs are three times higher for diabetes patients with multiple hospitalizations as compared to diabetes patients with a single stay in a given year. Patients with diabetes who are racial/ethnic minorities, enrolled in public insurance programs, or living in low-income communities are more likely to experience multiple hospitalizations and have higher hospital costs than their counterparts.</td>
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<tr>
<td>According to Pat Rutherford, RN, MS, vice president at the Institute for Healthcare</td>
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Improvement, hospitals can improve patients’ discharge from the hospital by enhancing current discharge processes and by making the following changes:

- Gain a deeper understanding of the comprehensive post-discharge needs of the patient through an ongoing dialogue with the family, caregivers, and community providers.
- Gain a deeper understanding of patient and family caregiver comprehension of the clinical condition and self-care needs after discharge.
- Develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers.
- Effectively communicate post-acute care plans to patients and community-based providers of care.

A readmission may result from incomplete treatment or poor care of the underlying problem, or may reflect poor coordination of services at the time of discharge and afterwards, such as incomplete discharge planning and/or inadequate access to care. Assessing the reason for readmissions is important not only as quality screens, but also because they are expensive, consuming a disproportionate share of expenditures for inpatient hospital care. The DAs can therefore focus their attention on the critical time of a patient’s acute illness when the patient is in transition between inpatient and outpatient phases of treatment.

PRMC’s hospital administrators and patient care unit directors view discharge planning as a major part of the solution to meet their financial woes, assuming that good discharge planning will reduce costs and increase reimbursement. Equally important, patients, and families value the discharge planning process, which has become a significant quality indicator for institutional accreditation. Specifically, JCAHO has established expectations that health care providers coordinate care and include patients in their planning of care, and has emphasized that the hospital staff should recognize that they are one part of an integrated system of health care practitioners, settings, and services.

Another key to the success of Project RED is to encourage patients and their family members or caregivers to ask questions and then ask them questions to verify their understanding of what they were just taught. The idea is to communicate to patients frequently, that it’s important to us that they ask questions and understand the answer. Some of our patients, in the past, have made comments about not wanting to ask questions because they feel that they’re being a burden when they ask them. PRMC and its staff will constantly reinforce that we want them to ask any questions they have so they can know as much as possible when/before they go home. The entire staff, including the non-clinical staff, such as social workers and dieters, will reinforce the need for patients to ask questions when they make rounds and invite them to ask questions. In addition to writing the discharge orders, physicians reconcile medication, and if the patients are getting new medication the DAs will make sure, they understand which medications at home they should continue to take or stop taking. The DAs will also call patients two days after discharge to make sure that all the patients’ questions are answered, and to find out if there are other issues, such as health workers not showing up or worsening in their condition that might potentially cause them to need to return to the hospital. They make sure the patients have a number to call with questions and concerns, and they have their medication and understand how to take it.

Using Project RED, the DA will educate the patient and their family members or caregivers on the patient’s reconciled medication list they will receive at discharge and the transition record (with all elements to be received by the patients PCP and specified elements to be received by patient/family/caregiver). Project RED’s components include timely transmission
Elements of the patients transition record will include:

1. Principal diagnosis and problem list (PCP and patient)
2. Medication list (reconciliation) including OTC/herbals, allergies and drug interactions (PCP and patient)
3. Clearly identified transferring physician/institution and their contact information (PCP and patient)
4. Patient’s cognitive status (PCP)
5. Test results/pending results (PCP and patient)

**Valuation:**
Please see last page for narrative on Valuation

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### Domain 3: Potentially Preventable Complications

**Description:**
An AHRQ publication (2005) reported, national inpatient hospital costs for diabetes with complications were nearly $3.8 billion in 2001. Up to about $2.5 billion—roughly two-thirds of the total—might have been averted with appropriate primary care for individuals with diabetes complications. A significant amount of these potential savings might have been obtained from public insurance programs. The Medicare program had the largest share of potentially preventable costs—$1.3 billion was attributable to diabetes-related hospital costs. Costs to the Medicaid program for potentially preventable hospital stays were $386 million.

As diabetes rates continue to rise in our community, substantial gaps in care for diabetes exist, preventable complications occur all too frequently, and the Nation is paying the price in higher health care costs and lower productivity and quality of life. Diabetes is the sixth most expensive condition nationally (Cohen and Krauss, 2003). On average, medical expenditure for a person with diabetes in 2002 cost more than $13,000 per year versus just $2,500 for the average person without diabetes (Hogan, Dall, Nikolov, 2003). About half of the lifetime, health care costs for patients with diabetes are related to potentially preventable complications (Herman and Eastman, 1998).

AHRQ also reports that diabetes has tremendous impact on both public and private health care spending and on the quality of life for those diagnosed with the disease. Yet Type 2 Diabetes, the most common form of diabetes, can be prevented and controlled. It is not inevitable that more Americans develop diabetes as they age, nor is it inevitable that people with diabetes experience the long-term complications such as lower limb amputations, kidney failure, and premature death.

As the health care reform unfolds, PRMC like many other hospitals are looking for ways to control costs while maintaining or improving quality. By implementing Project RED and disease management program targeting diabetes, we seek to increase patient knowledge and self-management skills and implement technology to track patients more effectively. Improved care management for diabetes is aimed at decreasing preventable complications, thereby controlling
costs and potentially improving long term health outcomes. A few of our goals in implementing this project include:

- Prevention of acute and long-term diabetic complications
- Providing quality of diabetes care to our community
- An intervention and treatment that can potentially prevent development of complications for diabetics
- The potential for return on investment for our health care system as a whole with diabetes quality improvement

The presence of too much glucose in the blood causes damage to blood vessels and, subsequently, to nerves, organs, and tissues; over time this results in various long-term complications, including: heart disease, hypertension, heart attacks, stroke, nerve damage, lower limb ulcers, eye problems and blindness, kidney disease or failure, critically high or low glucose levels and many other complications. None of the complications listed is a predestined outcome of having diabetes. With quality care and proper self-management education provider with Project RED, individuals with diabetes can prevent or delay the onset of these complications.

**Valuation:**
Please see last page for narrative on Valuation

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**Performing Provider**
Provider name: Peterson Regional Medical Center
TPI: 127294003

**Domain 4: Patient-Centered Healthcare**

**Description:**
Project RED was developed and tested ensuring components and strategies to improve the hospital discharge process in a way that promoted patient safety and reduced rehospitalization rates. Project RED was founded on 12 discrete and mutually reinforcing components, and has been proven to reduce rehospitalizations and yield high rates of patient satisfaction. It contains interventions that are patient-centered, and allows for a more standardized approach to discharge planning. Initially developed through research conducted by Dr. Brian Jack of the Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ), Project RED improves patient preparedness for self care and reduces preventable readmissions.

It is an in-hospital discharge planning and case management protocol for patients and incorporates many principles of patient-centeredness and self–care aimed at improving the patient's preparedness for self care and at reducing the likelihood of readmission. This intervention is a patient-centered, standardized approach to discharge planning and discharge education. Proper health care and patient empowerment can help control and minimize the complications of diabetes for those who have the disease.

Diabetes is a complicated chronic condition that requires patients to take charge of many aspects of their care. Project RED will encourage good patient self-management after discharge; this has been shown to decrease the rates of diabetes complications in other hospitals already using this model. Providing adequate information, good patient-physician communication, and the use of participatory decision-making are critical to enhancing patient self-management.
Measures that assess patients’ satisfaction with the information they are provided and the adequacy of self-management support will be considered as additions to technical measures for the evaluation of Project RED’s quality.

Patient self-management is particularly important for managing diabetes and preventing complications. Studies have demonstrated that patient self-management programs that include measures which are also used in Project RED are effective tools for improving patient outcomes. One Stanford University study funded by AHRQ found that over a 2-year period participants in a chronic disease self-management program showed reductions in health distress, made fewer visits to the doctor’s office and emergency room, had not experienced any further increases in disability and had increased self-efficacy (Lorig, Ritter, Stewart, et al., 2001). Systematic reviews of the literature on self-management programs for diabetes found positive effects on patients’ knowledge, self-monitoring of blood glucose, diet, and glycemic control (Norris, Nichols, Caspersen, et al., 2002; Norris, Engelgau, Narayan, 2001).

**Valuation:**

Please see last page for narrative on Valuation

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**Performing Provider**

Provider name: Peterson Regional Medical Center

TPI: 127294003

**Domain 5: Emergency Department**

**Description:**

Emergency departments (EDs) are an important consideration in today’s health policy dialogue. Previous studies note that annual ED visits have increased over time, while reimbursement for emergency care by insurers has steadily decreased. These challenges are magnified in rural areas, which typically have fewer health care resources, including medical staff, facilities, adequate financing, and modern technologies.

Our healthcare system will make system wide changes to better manage patients who have chronic disease such as diabetes; have emergency physicians work with case managers and community-based services; and improve collaboration between the emergency and primary-care teams. Using Project RED, hospital stays could possibly be prevented with better ambulatory care, improved access to effective treatment, or patient adoption of healthy behaviors. Proactively engaging a population of patients and focusing on their health goals, needs, and abilities to achieve desired health outcomes.

Reducing hospital admission rates for uncontrolled diabetes and for the short-term complications of diabetes, as with most other preventable hospital admissions, can be achieved by proper outpatient treatment and patient adherence to recommended care. Uncontrolled high blood or low blood sugar ultimately results in life-threatening short-term and/or long-term complications. While transition programs show promise in helping hospitals reduce their readmission rates, predictive models are also being used successfully in tandem with these programs.

One AHRQ-sponsored study conducted by Stanford University researchers showed that 2 years after participating in a self-management program, study participants showed reductions in health distress, made fewer visits to the doctor’s office and emergency room, had not...
experienced any further increases in disability, and had increased self-efficacy (Lorig, Ritter, Stewart, et al., 2001).

Valuation:
Please see last page for narrative on Valuation

Performing Provider
Provider name: Peterson Regional Medical Center
TPI: 127294003
**OPTIONAL Domain 6: Children and Adult Core Measures**

Description:
As an organization, we have chosen not to report on Optional Domain 6 at this time.

**Category 4 VALUATION for ALL Domain Measures**

Valuation:

Deciding which health care options represent best value for money depends on being able to weigh up the benefits and costs of each. Given a fixed budget, spending on one option means those same resources cannot be used in another way. That is, every decision carries an opportunity cost – the benefits that would have been possible from the next best alternative use of them. Weighing up the benefits possible from each potential option imposes the important requirement that the benefits be measured in a comparable way. This task requires an evaluation of the costs and effects (outcomes) of different treatments.

The measure, known as the quality, weighs the outcome of an intervention also to include the patient’s perception/experience of that intervention and its outcome. Assessing value for money in health care involves evaluating the change in quality that is caused by the treatment relative to the cost of achieving those quality gains. Patient reported outcome measures are now beginning to capture important aspects of health care’s impact on the things that patients most value - their mental wellbeing, their ability to carry out normal physical activities, understanding of their disease and treatment of it, their discharge experience and so on. Healthcare process improvements, like any other area of public policy, have to be about making people’s lives better.

Outcome measures designed for use in healthcare services provide a way of monitoring impact of innovative patient care models and to compare the impact of different interventions to evaluate their impact on patient outcomes as well as their value on health care costs. The ultimate goal of quality measurement in diabetes is to motivate quality improvement and decrease long-term diabetes complications within and throughout our community and those that
surround it.

There is evidence that some improvements in processes of care are motivated by the quality monitoring process itself, especially when incentives for better performance were incorporated. We anticipate seeing this once Project RED has been implemented. Project RED has been demonstrated to be effective in ensuring patients have clear and correct instructions, solid education and appropriate follow up care that result in meeting the needs of each of these quality measures in some way, shape or form. This project will allow PRMC to help patients realize the value of this evidence based approach while improving the quality of their care in our health care system.

References:


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**Domain 1: Potentially Preventable Admissions (PPAs)**

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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

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**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

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**Domain 4: Patient Centered Healthcare**

*Patient Satisfaction - HCAHPS*

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*Medication Management*

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<td>$226,905</td>
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Performing Provider
Performing Provider name: Southwest General Hospital
TPI: 136491104

Domain 1: Potentially Preventable Admissions

Description:

Project 1: Through the development of a mobile specialty care unit dedicated to vascular screening, the surrounding rural communities will have the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. Through the goal of improving access to specialty care, the project will impact the following:

- Enhance availability of resources to assess and refer residents of rural communities for cardiovascular healthcare resulting from mobile screening assessment, which could also result in incidental recognition/detection of signs and symptoms of CHF, adult COPD/asthma, new onset of diabetes and hypertension.
- By early recognition/detection, referral and treatment of these disease processes this could decrease ED utilization and inpatient admissions thru early intervention and management as an outpatient.
- Pneumococcal and influenza vaccination screening could be included in the mobile screening assessment.

Project 2 - Through the development of a Gestational Diabetes Program for RHP 6 region, pregnant women at risk for or diagnosed with gestational diabetes will have access to high-quality, patient centered care with the goal of improved outcomes for mother and baby. Through the goal of early identification, management and education of gestational diabetes in the pregnant woman, the project could result in:

- A decrease in hospital admissions due to undiagnosed gestational diabetes and/or resultant stillbirths.
- A decrease in hospital days for both mother and baby for birth of newborn.
- A decrease in babies admitted to the NICU due to premature delivery, low birth weight and birth trauma related to diabetes in pregnancy.
  - A decrease in fetal deaths due to undiagnosed or poorly managed gestational diabetes in the pregnant woman.

Through the implementation of a structured Gestational Diabetes program involving Obstetricians and Maternal Fetal Medicine physicians, perinatal nurses and a diabetic educator pregnant women in the RHP6 region would have access to care on a flexible outpatient basis that would meet their needs.

Valuation:

Project 1 - The approach for valuing each domain and rationale/justification would be as follows:

CHF - currently the hospital participates in Core Measure (HF is one of the measures) reporting through CMS. The number of CHF cases identified and referred through incidental recognition and intervention during the mobile assessment screening could be tracked and compared to the number of the CHF patients admitted at our facility. Cost avoidance would be evidenced each time early diagnosis, intervention, referral and treatment was provided that resulted in avoidance of ED utilization and/or hospital admission.

Adult COPD/asthma and hypertension - The number of COPD/asthma and hypertension cases identified and referred through incidental recognition and intervention could be tracked and compared to the number of the COPD/asthma and hypertensive patients admitted and treated at our facility for the same time period through utilization of CPT codes. Cost avoidance would be
evidenced each time early diagnosis, intervention, referral and treatment was provided that resulted in avoidance of ED utilization and/or hospital admission for these diagnoses.

**Diabetes**-Currently Healthways, Inc. manages the Diabetes Service Line within the facility. The number of newly diagnosed cases identified and referred through incidental recognition and intervention during the mobile assessment screening could be tracked and compared to the number of the newly diagnosed patients admitted and treated at our facility. The project scope would include adults diagnosed with newly diagnosed diabetes within RHP 6.

**Pneumococcal and influenza vaccination**-By providing pneumococcal and influenza vaccines through the mobile specialty care unit screening this would provide another avenue for the targeted population to receive preventative care. The number of patients admitted for pneumonia and influenza could be tracked, trended and compared to previous years to determine if this additional vaccination site impacted ED utilization as well as hospital.

**Project 2**- The project for Southwest General Hospital is designed to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for services and thus have increased access to services. Southwest General Hospital will develop and implement a Gestational Diabetes program to educate and monitor patients, therefore, improving fetal outcomes.

Valuation could be realized thru:
- Number of ED visits and hospital admissions resulting from undiagnosed or poorly managed gestational diabetes could be monitored, measured and compared to present as well as previous years admissions.
- Number of births admitted to NICU of mothers with gestational diabetes could be monitored, measured and compared to present as well as previous years admission.
- Number of clinic visits and referrals could be monitored and measured to determine utilization of program by pregnant women in the RHP 6 region.

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<tr>
<td><strong>Domain 2: Potentially Preventable Readmissions – 30 days</strong></td>
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<tr>
<td><strong>Description:</strong></td>
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<tr>
<td><strong>Project 1</strong></td>
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<tr>
<td>• The Mobile Cardiovascular Screening Program will contribute to assuring patients receive high-quality, patient centered care with the goal of improved access to care to support the identification and intervention for cardiovascular problems and any other disease processes incidentally identified during the assessment process such as CHF, COPD/asthma, new onset of diabetes and hypertension.</td>
</tr>
<tr>
<td>• By incidental recognition/detection, referral and treatment of these disease processes ED utilization and inpatient admissions could be decreased as well as readmissions thru early intervention and management as an outpatient.</td>
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<tr>
<td>• Since many of the patients treated within RHP 6 have co-morbidities any incidental</td>
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identification and management during the mobile screening possess could potentially avoid an acute exacerbation of the co-morbidity thus decreasing ED utilization and possible hospital admission.

- By providing easier and more convenient access to services such as pneumococcal and influenza vaccines the incidence of pneumonia and flu cases should be decreased in RHP 6 and thus resulting in decreased ED utilization and hospital admission not only by person screened but by avoidance of transmission of disease to others due to having been vaccinated.

**Project 2**

- Of the 7 potentially preventable readmissions listed the impact that the Gestational Diabetes program and clinic would have the greatest impact on would be diabetes. With screening, identification, education and provision of prenatal care for the pregnant woman with gestational diabetes this could greatly decrease preventable readmissions.

- Unless pre-existing conditions of CHF, Behavioral Health and Substance Abuse, COPD and Stroke existed in population domain measures would be exempt.

**Valuation:**

**Project 1**
The valuation for this domain is not applicable as this does not pertain to the vascular screening mobile assessment project which is outpatient.

**Project 2**
To evaluate the usage and effectiveness of the Gestational Diabetes program by pregnant women of the RHP 6 region readmissions due to diabetes would need to be monitored. Internal reports already available could be utilized without additional costs.

**Performing Provider**
Performing Provider name: Southwest General Hospital
TPI:136491104

**Domain 3: Potentially Preventable Complications**

**Description:**

**Project 1**-The potentially preventable complications related to the mobile specialty care unit for vascular screening relate to the decrease in ED utilization and hospital admission. By early recognition and outpatient management of not only cardiovascular disease but any incidental disease processes identified during the screening the multiple complications associated with inpatient admission could be prevented to include:

- Pneumonia and Other Lung Infections
- Pulmonary Embolism
- Shock
- Venous Thrombosis
- Clostridium Difficile Colitis
• Urinary Tract Infection
• Decubitus Ulcer
• Other Complications of Medical Care
• Inflammation and Other Complications of Devices, Implants or Grafts Except Vascular Infection
• Infection, Inflammation and Clotting complications of Peripheral Vascular Catheters and Infusions
• Infections Due to Central Venous Catheters

Since the cardiovascular screening is non-invasive none of the above preventable complications would be applicable, whereas an ED visit or inpatient admission could potentially be susceptible to the above complications during the course of treatment.

Project 2-
Of the potentially preventable complications listed expected improvements would be seen in the following for those pregnant women who accessed and utilized the services offered by the Gestational Diabetes clinics:
• Pulmonary embolism
• Shock
• Urinary Tract Infection
• Poisonings due to Anesthesia
• Transfusion Incomptability Reaction
• Post-operative Infection and Deep Wound Disruption with Procedure
• Diabetic Ketoacidosis and Coma
• Obstetrical Hemorrhage without transfusion
• Obstetrical Hemorrhage with Transfusion
• Obstetric Lacerations and other Trauma without Instrumentation
• Obstetric Lacerations and other Trauma With Instrumentation
• Medical and Anesthesia Obstetric Complications
• Major Puerperal Infection and Other Major Obstetric Complications
• Other Complications of Obstetrical Surgical and Perineal Wounds
• Delivery with Placental Complications
• Other In-Hospital Adverse Events

Valuation:

Project 1
Refer to Project Description, Starting Point/Baseline, Rationale and Related Category 3 Outcome Measure and Project Valuation for specific size factor, project scope, populations served, community benefit, cost avoidance, addressing community need and estimated local funding.

Project 2
The potentially preventable complications listed above do not directly pertain to the Gestational Diabetes Program and clinic but to the resultant hospitalization for mother and baby upon delivery of the newborn. The above could be tracked and trended for those pregnant women with gestational diabetes who utilized the services and resources related to the Gestational Diabetes Program versus those that did not.
### Domain 4: Patient-Centered Healthcare

**Description:**

**Projects 1 and 2**

The reporting of Patient Satisfaction and Medication Management measures are limited to the inpatient setting. Southwest General Hospital will report on these measures though the identified project will not affect the measures.

**Valuation:**

The reporting of Patient Satisfaction and Medication Management measures are limited to the inpatient setting. Southwest General Hospital will report on these measures though the identified project will not affect the measures.

---

### Domain 5: Emergency Department

**Description:**

**Project 1**

The reporting of the Emergency Department measure will be reported but the SWGH project will not affect the measures.

**Project 2**

This ED measure does not directly relate to the Gestational Diabetes program project. The reporting of the Emergency Department measure will be provided but the SWGH project will not affect the measures.

**Valuation:**

**Project 1**

The reporting of the Emergency Department measure will be reported but the SWGH project will not affect the measures.

**Project 2**

This ED measure does not directly relate to the Gestational Diabetes program project. The reporting of the Emergency Department measure will be provided but the SWGH project will not affect the measures.

No Domain 6 as referenced in Notebook
# Category 4: Population-Focused Measures

*Southwest General Hospital  TPI: 136491104*

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td><strong>Capability to Report Category 4</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</strong></td>
<td><strong>Status report submitted to HHSC confirming system capability to report Domains 3.</strong></td>
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</table>

| **Estimated Maximum Incentive Amount** | $55,256 | $21,350 | |

## Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $21,350

## Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $21,350

## Domain 3: Potentially Preventable Complications (PPCs)

- **Includes a list of 64 measures identified in the RHP Planning Protocol.**
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $22,839

## Domain 4: Patient Centered Healthcare

### Patient Satisfaction - HCAHPS

- **Measurement period for report:** October 1, 2013 – September 30, 2014
- **Planned Reporting Period:** 1 or 2

### Medication Management

- **Measurement period for report:** October 1, 2013 – September 30, 2014
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<tr>
<th></th>
<th>Domain 4 - Estimated Maximum Incentive Amount</th>
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<td>Domains reported: 2015-2016</td>
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**Domain 5: Emergency Department**

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<tr>
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<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
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<th>Domain 6: Children and Adult Core Measures</th>
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|                           | Grand Total Payments Across Category 4 | $55,256 | $84,400 | $114,195 | $124,125 |
Performing Provider:
Performing Provider name: Texas Center for Infectious Disease
TPI: 133257904

**Domain 4: Patient-Centered Healthcare**

**Description:**
This system redesign demonstration project (2.7.6 “Other”) is structured to transform the treatment of TB for patients who live in an urban (RHP Region 6) of the state to demonstrate an evidence-based regime for the diagnosis of Latent TB Infection (LTBI) using interferon gamma release assays instead of tuberculin skin testing to minimize false positives; and to provide routine treatment for LTBI using a 12 dose, 12 week regimen administered by Direct Observed Therapy. In addition, the project will facilitate hospitalization for TB care of those patients who cannot be successfully treated as outpatients, thereby reducing the risk of disease spread. The Category 2 metrics for this project include I-7-1: Increase the percentage of relevant minority target populations in RHP 6 by 3% over baseline and I-7.2: Increase the number of encounters as defined by the intervention. The related Category 3 Improvement Target is: IT-11.1 Improvement in the clinical indicator in the identified Disparity Group.

Category 4 RD 1-3 Do not apply to this demonstration project because, as a specialty hospital the number of preventable admissions, readmissions, and potentially preventable complications is statistically insignificant for reporting purposes.

As such, the appropriate Category 4 measure that will demonstrate improvement resulting from program implementation is Domain 4: Patient Centered Healthcare. Within Domain 4 the standardized Patient Satisfaction Tool, HCAHPS will be used to assess patient satisfaction with the categories of interaction with the healthcare system and providers. Critical to the successful management of TB for those patients who require hospitalization is adherence to the patient care plan. Therefore, the Domain 4 category of Medication Management is the second metric that will be used for Category 4 reporting.

RD5 – Emergency Department reporting does not apply. This specialty hospital does not have an emergency department.

**Valuation:**
TB continues to be a significant and expensive public health issue in Texas. The project includes targeted testing for latent TB infection (LTBI), effective treatment of LTBI in order to **prevent** future cases, case identification with referral for appropriate therapy (inpatient or outpatient) with aggressive contact investigation. The project will be implemented in **RHP 6** to demonstrate a model of case identification and treatment delivery that is effective in reducing the spread of the disease while providing **better health outcomes with improved patient satisfaction**. Minority populations especially those who are poor, continue to experience an undue burden of this chronic, infectious disease. Effective new treatment regimens are available however, not implemented broadly enough at this time to reduce the spread of the disease. People who do not have access to primary care services are the least likely to be diagnosed with LTBI and therefore, present a risk for spreading as well as developing the disease. This creates an unnecessary burden on the healthcare system that can be managed and avoided. The valuation of this project is justified.
based on the following elements that will improve access to care, improve patient satisfaction, reduce health care costs, improve the health of populations, and provide access to specialty consultation 24 hours per day, seven days per week.

- The project will serve residents of one large urban region of Texas
- The project will be provided through the Texas Center for Infectious Disease which specializes in treatment of tuberculosis.
- Targets minority populations who are at highest risk for disease exposure and spread with an evidence-base, cost-effective management and prevention strategy
- Provides enhanced access to comprehensive, fully integrated TB care
- This approach will reduce the current and future financial burden on the healthcare system by contributing to the decline of TB rates among Texas residents.
## Category 4: Population-Focused Measures

*Texas Center for Infectious Disease / 133257904*

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<thead>
<tr>
<th></th>
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<td>Milestone: Status report</td>
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</tr>
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</table>

**Estimated Maximum Incentive Amount**

- Year 2: $\_\_
- Year 3: $\_\_
- Year 4: $\_\_
- Year 5: $\_\_

### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $\_\_

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $\_\_

### Domain 3: Potentially Preventable Complications (PPCs)

- **Includes a list of 64 measures identified in the RHP Planning Protocol.**
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $\_\_

### Domain 4: Patient Centered Healthcare

- **Patient Satisfaction - HCAHPS**
  - Measurement period for report: October 1 – September 30
  - Planned Reporting Period: 1 or 2
  - Domain 4 - Estimated Maximum Incentive Amount: $384,634

- **Medication Management**
  - Measurement period for report: October 1 – Sept 30
  - Planned Reporting Period: 1 or 2
  - Domain 4 - Estimated Maximum Incentive Amount: $384,634

- **Yearly Incentive Amounts**
  - Year 2: $384,634
  - Year 3: $384,634
  - Year 4: $428,100
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<tr>
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<td></td>
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<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
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**OPTIONAL Domain 6: Children and Adult Core Measures**

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<tr>
<th>Domain 6 - Estimated Maximum Incentive Amount</th>
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</table>

| Grand Total Payments Across Category 4 | $0 | $384,634 | $384,634 | $428,100 |
Performing Provider
Performing Provider name: University Hospital
TPI: 136141205

**Domain 1: Potentially Preventable Admissions**

**Description**

**Relationship to Category 1,2,3 projects:**
University Hospital projects were selected to impact the triple aim-plus goals of assuring patients receive high-quality care, improved patient experience, cost effectiveness, and improved access to meet our community needs. Specific projects related to **Potentially Preventable Admissions** include the following:

- **1.1.1** – Establish more primary care clinics: Partner with a local FQHC to establish and expand clinical and community preventive services via the patient-centered medical home and thereby expand access to care to a rapidly growing section of Bexar County, Texas.

- **1.9.2** – Expand access to specialty care (outpatient psychiatry): Increase access to specialty care by expanding its provider base and having patients receive behavioral health services through its integrated patient-centered medical home.

- **1.1.3** – Expand mobile clinics: Expand a mobile health clinic within major urban school districts.

- **2.12.1** – Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Implement a care transitions program specifically to address the window of time between discharge and either a return EC visit and/or PCP/clinic visit.

- **2.10.1** – Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service: Provide access to comprehensive supportive care services for patients in Bexar County who are at risk for serious illness and to improve quality of life for patients and families facing serious illness through intensive communication, pain and symptom management, advanced care planning, and coordination of care.

- **2.11.2** – Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors: Dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease medication management among the patients assigned to that clinic.

- **IT-9.3** – Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381

- **IT-1.18** – Follow-Up After Hospitalization for Mental Illness- NQF 0576236

- **IT-2.13** – Other Admission Rate

- **IT – 10.1** – Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for the target population
University Hospital expects these projects to result in improved outcomes for this domain’s measures to benefit the RHP population by reducing potentially preventable admissions related to congestive heart failure; diabetes; behavioral health and substance abuse; chronic obstructive pulmonary disease or asthma in adults; hypertension; and pediatric asthma returns to ED visit within 15 days. University Hospital expects increases in bacterial pneumonia immunization rates and influenza immunization rates.

Valuation
University Hospital values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing these projects, University Hospital took into account the extent to which Potentially Preventable Admissions reporting could meet the goals of the Wavier, the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

Performing Provider
Performing Provider name: University Hospital
TPI: 136141205

Domain 2: Potentially Preventable Readmissions – 30 days

Description

Relationship to Category 1,2,3 projects:
University Hospital projects were selected to impact the triple aim-plus goals of assuring patients receive high-quality care, improved patient experience, cost effectiveness, and improved access to meet our community needs. Specific projects related to Potentially Preventable Readmissions – 30 days include the following:

- 1.1.1 – Establish more primary care clinics: Partner with a local FQHC to establish and expand clinical and community preventive services via the patient-centered medical home and thereby expand access to care to a rapidly growing section of Bexar County, Texas.
- 1.9.2 – Expand access to specialty care (outpatient psychiatry): Increase access to specialty care by expanding its provider base and having patients receive behavioral health services through its integrated patient-centered medical home.
- 1.1.3 – Expand mobile clinics: Expand a mobile health clinic within major urban school districts.
- 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Implement a care transitions program specifically to address the window of time between discharge and either a return EC visit
and/or PCP/clinic visit.

- 2.10.1 – Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service: Provide access to comprehensive supportive care services for patients in Bexar County who are at risk for serious illness and to improve quality of life for patients and families facing serious illness through intensive communication, pain and symptom management, advanced care planning, and coordination of care.

- 2.11.2 – Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors: Dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease medication management among the patients assigned to that clinic.

- IT-9.3 – Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381
- IT-1.18 – Follow-Up After Hospitalization for Mental Illness- NQF 0576236
- IT-2.13 – Other Admission Rate
- IT – 10.1 – Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for the target population
- IT – 12.1 – Breast Cancer Screening
- IT – 12.2 – Cervical Cancer Screening
- IT – 12.3 – Colorectal Cancer Screening

**Expected Improvements:** University Hospital expects these projects to result in improved outcomes for this domain’s measures to benefit the RHP population by reducing potentially preventable 30-day readmissions related to congestive heart failure; diabetes; behavioral health and substance abuse; chronic obstructive pulmonary disease; stroke; pediatric asthma; and all-cause readmissions with exclusions as noted in the RHP Planning Protocol.

**Valuation**

University Hospital values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing these projects, University Hospital took into account the extent to which Potentially Preventable Readmissions – 30 days reporting could meet the goals of the Wavier, the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
Performing Provider

Performing Provider name: University Hospital
TPI: 136141205

Domain 3: Potentially Preventable Complications

Description:

Relationship to Category 1,2,3 projects:
University Hospital projects were selected to impact the triple aim-plus goals of assuring patients receive high-quality care, improved patient experience, cost effectiveness, and improved access to meet our community needs. Specific projects related to Potentially Preventable Complications include the following:

- 1.1.1 – Establish more primary care clinics: Partner with a local FQHC to establish and expand clinical and community preventive services via the patient-centered medical home and thereby expand access to care to a rapidly growing section of Bexar County, Texas.

- 1.1.2 – Expand existing primary care capacity: Expand existing primary care clinic space, expand hours of operations at primary care clinic sites and expand the primary care clinic staffing.

- 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency: Implement the Lean methodology to determine the use of materials and human resources, improve value to the patient, distinguish how and why inputs into certain processes translate into value, and find ways to eliminate wasteful components.

- 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Implement a care transitions program specifically to address the window of time between discharge and either a return EC visit and/or PCP/clinic visit.

- IT-9.3 – Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381

- IT – 10.1 Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for the target population

Expected Improvements: University Hospital expects the above projects to result in improved outcomes for the 64 risk-adjusted rates listed for this domain in the RHP Planning Protocol.

Valuation

University Hospital values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing these projects, University Hospital took into account the extent to which Potentially Preventable Complications reporting could meet the goals of the Wavier, the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
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<th>Performing Provider name: University Hospital</th>
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<tbody>
<tr>
<td>TPI: 136141205</td>
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<tr>
<td><strong>Domain 4: Patient-Centered Healthcare</strong></td>
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**Description**

**Relationship to Category 1,2,3 projects:**
University Hospital projects were selected to impact the triple aim-plus goals of assuring patients receive high-quality care, improved patient experience, cost effectiveness, and improved access to meet our community needs. Specific projects related to **Patient-Centered Healthcare** include the following:

- **1.7.1** – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Employ telemedicine services to the Medicaid and uninsured pediatric/young adult asthma patient populations in the ambulatory setting.

- **2.9.1** – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Establish and enhance patient navigators consisting of social workers and case managers beyond acute care and within the emergency center and defined ambulatory clinics to support the patients within the region. The project will work as a support network and educational system to aid and facilitate patient activation and empowerment.

- **1.1.3** – Expand mobile clinics: Expand a mobile health clinic within major urban school districts.

- **1.4.1** – Expand Access to Written and Oral Interpretation Services: Strengthen access to culturally competent patient-centered care through strategies that promote timely oral interpretation/translation services, improve the fluid exchange of health information between patients and healthcare professionals and promote opportunities for patient to adhere to prescribed clinical care and treatment regimens.

- **2.4.1** – Implement processes to measure and improve patient experience: Develop and implement a comprehensive patient experience training program.

- **2.10.1** – Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service

- **2.7.1** – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammograms, immunizations): Implement an innovative community-based intervention model to increase access to clinical preventive services throughout Bexar County, Texas.

- **2.11.2** – Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors: Dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease
medication management among the patients assigned to that clinic.

- IT-6.1 – Percent improvement over baseline of patient satisfaction scores
- IT-13.1 – Pain assessment (NQF-1637)
- IT-13.2 – Treatment Preferences (NQF 1641)
- IT-13.5 – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified)

**Expected Improvements:** University Hospital expects the above projects to result in improved outcomes for patient satisfaction as measured by HCAHPS and CG-CAPHS as well as improved medication management.

**Valuation**
University Hospital values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing these projects, University Hospital took into account the extent to which Patient-Centered Healthcare reporting could meet the goals of the Wavier, the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.

**Performing Provider**
Performing Provider name: University Hospital
TPI: 136141205
**Domain 5: Emergency Department**

**Relationship to Category 1,2,3 projects:**
University Hospital projects were selected to impact the triple aim-plus goals of assuring patients receive high-quality care, improved patient experience, cost effectiveness, and improved access to meet our community needs. Specific projects related to Emergency Department include the following:

- 1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Employ telemedicine services to the Medicaid and uninsured pediatric/young adult asthma patient populations in the ambulatory setting.

- 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency: Implement the Lean methodology to determine the use of materials and human resources, improve value to the patient, distinguish how and why inputs into certain processes translate into value, and find ways to eliminate wasteful components.
- IT-9.2 – ED Appropriate Utilization

**Expected Improvements:** University Hospital expects the above projects to result in improved outcomes for patients resulting in improved admit decision time to ED departure time for admitted patients.

**Valuation**

University Hospital values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. In valuing these projects, University Hospital took into account the extent to which *Emergency Department* reporting could meet the goals of the Wavier, the extent to which it will address the community needs, the population served, and resources and costs necessary to implement the project.
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<tr>
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<td>$2,110,612</td>
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**Domain 1: Potentially Preventable Admissions (PPAs)**

**Planned Reporting Period:** 1 or 2

**Domain 1 - Estimated Maximum Incentive Amount**

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<th>1: October 1 – March 31</th>
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<tbody>
<tr>
<td>$2,110,612</td>
<td>$2,279,835</td>
<td>$2,500,562</td>
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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

**Planned Reporting Period:** 1 or 2

**Domain 2 - Estimated Maximum Incentive Amount**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>1: October 1 – March 31</th>
<th>1: October 1 – March 31</th>
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<td>$2,110,612</td>
<td>$2,279,835</td>
<td>$2,500,562</td>
<td></td>
</tr>
</tbody>
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**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

**Planned Reporting Period:** 1 or 2

**Domain 3 - Estimated Maximum Incentive Amount**

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>1: October 1 – March 31</th>
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<tbody>
<tr>
<td>$2,279,835</td>
<td>$2,500,562</td>
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**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

**Measurement period for report**

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<th>10/1/2012 – 9/30/2013</th>
<th>10/1/2012 – 9/30/2013</th>
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<tr>
<td>2: April 1 – Sept. 30</td>
<td>2: April 1 – Sept. 30</td>
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**Planned Reporting Period:** 1 or 2
### Medication Management

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<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2: April 1 – Sept. 30</td>
<td>2: April 1 – Sept. 30</td>
<td>2: April 1 – Sept. 30</td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$2,110,612</td>
<td>$2,279,835</td>
<td>$2,500,562</td>
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</tbody>
</table>

### Domain 5: Emergency Department

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<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2: April 1 – Sept. 30</td>
<td>2: April 1 – Sept. 30</td>
<td>2: April 1 – Sept. 30</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$2,110,612</td>
<td>$2,279,835</td>
<td>$2,500,562</td>
</tr>
</tbody>
</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

| Domain 6 - Estimated Maximum Incentive Amount | $0.00 | $0.00 | $0.00 |

### Grand Total Payments Across Category 4

| $4,439,682 | $10,553,060 | $11,399,175 | $12,502,810 |
**Performing Provider:**
Performing Provider: Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital (UMH)
TPI: 121782003

**Domain 1: Potentially Preventable Admissions**

**Description:**

**Congestive Heart Failure (CHF) Admission rate** – related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer will be admitted for CHF. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including CHF) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the CHF admission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact CHF admission rates throughout the region.

**Diabetes Admission Rates** – related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer diabetic patients will be admitted. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including Diabetes) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the diabetic admission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact diabetes admission rates throughout the region.

**Behavioral Health and Substance Abuse Admission rate** - This reporting measure is unlikely to be affected by currently planned DSRIP projects.

**Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission rate** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer will be admitted for COPD. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including COPD) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the COPD admission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact COPD admission rates throughout the region.

**Hypertension Admission rate** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer will be admitted for Hypertension. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including Cardiovascular Disease/Hypertension) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the Hypertension admission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact Hypertension admission rates throughout the region.

**Pediatric Asthma** – This reporting measure is unlikely to be affected by currently planned DSRIP projects.

**Bacterial pneumonia immunization** – This reporting measure is unlikely to be affected by currently planned DSRIP projects.
**Influenza Immunization** – This reporting measure is unlikely to be affected by currently planned DSRIP projects.

**Valuation:**
The dollar amount we have allocated to each required category 4 reporting domain was divided proportionally between all required reporting domains. Since almost all reporting measures have not been measured or reported, previous to this 1115 Medicaid Waiver, the effort and means necessary to report this data was deemed to be of equal value across all reporting domains.

**Performing Provider:**
Performing Provider: Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital (UMH)
TPI: 121782003

**Domain 2: Potentially Preventable Readmissions – 30 days**

<table>
<thead>
<tr>
<th>Description</th>
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</table>
| **Congestive Heart Failure (HF): 30-Day Readmissions** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer will be re-admitted for CHF. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including CHF) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the CHF re-admission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact CHF readmission rates throughout the region.

**Diabetes: 30-Day Readmissions** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer diabetic patients will be re-admitted. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including Diabetes) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the diabetic readmission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact diabetes readmission rates throughout the region.

**Behavioral health & Substance Abuse: 30-day Readmissions** - This reporting measure is unlikely to be affected by currently planned DSRIP projects.

**Chronic Obstructive Pulmonary Disease (COPD): 30-day Readmissions** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer will be re-admitted for COPD. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization (reduced ED admits for target conditions – including COPD) and 121782003.3.1 – All cause 30 day readmission rate. Achieving reductions in these rates will directly impact the COPD readmission rate. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which would directly impact COPD readmission rates throughout the region.

**Stroke: 30-day Readmissions** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more
effectively manage their condition(s), fewer will be readmitted for stroke. Improvement in one of the Category 3 outcomes linked to 121782003.1.1 will also impact 30-day stroke readmissions. This outcome, 21782003.3.1, is the all-cause 30-day readmission rate. Reducing this rate throughout the project may also reduce stroke readmissions. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which could directly impact 30-day stroke readmission rates throughout the region.

**Pediatric Asthma: 30-day Readmissions** - This reporting measure is unlikely to be affected by currently planned DSRIP projects.

**All-Cause: 30-Day Readmissions** - related to: 121782003.1.1. This project teaches chronic disease patients how to manage their condition(s) and health effectively. If chronic disease patients more effectively manage their condition(s), fewer may be re-admitted for all causes. The Category 3 measures associated with this project are related to and will impact this Category 4 measure. These Cat. 3 outcomes are: 121782003.3.2 – ED appropriate utilization and 121782003.3.1 – All-cause 30-day readmission rate. Achieving reductions in these rates will directly impact all-cause 30-day readmissions. This project is also focused on filling RHP 6 community needs (CN.1 and CN.2), the fulfillment of which may reduce all-cause 30-day readmissions throughout the region.

**Valuation:**
The dollar amount we have allocated to each required category 4 reporting domain was divided proportionally between all required reporting domains. Since almost all reporting measures have not been measured or reported, previous to this 1115 Medicaid Waiver, the effort and means necessary to report this data was deemed to be of equal value across all reporting domains.

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**Performing Provider:**
Performing Provider: Uvalde County Hospital Authority, DBA Uvalde Memorial Hospital (UMH)
TPI: 121782003

**Domain 3: Potentially Preventable Complications**

**Description:**
At this time, none of the planned DSRIP projects are likely to have an impact on any of the 64 PPC measures.

**Valuation:**
The dollar amount we have allocated to each required category 4 reporting domain was divided proportionally between all required reporting domains. Since almost all reporting measures have not been measured or reported, previous to this 1115 Medicaid Waiver, the effort and means necessary to report this data was deemed to be of equal value across all reporting domains.
### Domain 4: Patient-Centered Healthcare

**Description:**

**Patient Satisfaction** – related to: 121782003.2.1 This project will impact patient satisfaction as palliative care appropriate patients will receive consults from the palliative care team. This team will be focused on the relief of suffering as well as the cure of disease. They will work to improve the quality of life for patients and their families by efficiently transitioning them from inpatient care to care settings that best fit patients’ needs. Specifically, this palliative care project has the potential to impact patient satisfaction through accomplishment of Cat. 3 improvement targets (3.IT-13.1, 3.IT-13.2, 3.IT-13.5) and through monitoring of patient/family satisfaction (accomplished through I-12). Milestone goals for DY 4 and DY 5 have been set for I-12. A 15% improvement in DY 4 patient/family experience survey scores over DY 3 and a 25% improvement in DY 5 patient/family experience survey scores over DY 3. Reaching these improvement goals has the potential to impact overall inpatient satisfaction scores for the hospital.

**Medication management** - 121782003.2.1 This project’s palliative care team will have little or no impact on medication management as defined by the DSRIP planning protocol. However, the palliative care team will provide consults to palliative care appropriate patients. Part of the consult will be devoted to pain/symptom management through appropriate medications. In this way, quality of life will be improved and medication management may also be influenced and/or improved indirectly.

**Valuation:**

The dollar amount we have allocated to each required category 4 reporting domain was divided proportionally between all required reporting domains. Since almost all reporting measures have not been measured or reported, previous to this 1115 Medicaid Waiver, the effort and means necessary to report this data was deemed to be of equal value across all reporting domains.

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### Domain 5: Emergency Department

**Description:**

At this time, none of the planned DSRIP projects are likely to have an impact on “Admit decision time to ED departure time for admitted patients (NQF 0497)”.

**Valuation:**

The dollar amount we have allocated to each required category 4 reporting domain was divided proportionally between all required reporting domains. Since almost all reporting measures have not been measured or reported, previous to this 1115 Medicaid Waiver, the effort and means necessary to report this data was deemed to be of equal value across all reporting domains.
### Category 4: Population-Focused Measures

**Uvalde Memorial Hospital / 121782003**

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<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
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**Domain 1: Potentially Preventable Admissions (PPAs)**

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<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
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<td>$75,259</td>
<td>$81,783</td>
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**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

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<tbody>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$70,298</td>
<td>$75,259</td>
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**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
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<tbody>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
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<td>$81,783</td>
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**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction – HCAHPS**

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**Medication Management**

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<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$ 70,298</td>
<td>$ 75,259</td>
<td>$ 81,783</td>
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<td>Measurement period for report</td>
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<td>$ 70,298</td>
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<td>$ 81,783</td>
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<td><strong>OPTIONAL Domain 6: Children and Adult Core Measures</strong></td>
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<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
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<td>$ 376,297</td>
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Performing Provider:
Performing Provider name: Val Verde Regional Medical Center (VVRMC)
TPI: 119877204
Domain 1: Potentially Preventable Admissions
Description:
The overwhelming outcome of the Val Verde County/Del Rio community needs assessment was to increase the supply of medical providers to our rural, medically-underserved community. As such, VVRMC has chosen DSRIP projects that will aim to expand access to care, both primary and specialty care. RD-1 (potentially preventable admissions) ought to be favorably impacted—all other things equal—by virtue of having more primary care providers and specialists among the community.

**Congestive Heart Failure (CHF) Admission rate** – related to: 119877204.1.1, 119877204.1.2, 119877204.1.3. All three projects have the potential to reduce the hospital’s CHF admission rate. In 119877204.1.1, VVRMC will expand primary care capacity. This increased access to primary care providers should correlate with a higher percentage of the population receiving regular health screenings and check-ups. As primary care capacity expands, providers will have more time to ensure best practices (e.g. patient follow-up) are followed concerning chronic disease management. This will improve CHF prevention efforts and may reduce the CHF admission rate. In 119877204.1.2 specialty care capacity will be expanded. One targeted specialty for expansion is cardiology. Increasing patient access to cardiologists has the potential to reduce CHF admissions through prevention and disease management. In 119877204.1.3, a telemedicine program will be developed for specialties where permanent specialist recruitment is not feasible (see 119877204.1.2). This may include cardiology, in which case a telemedicine program allowing access to a cardiologist should have some impact on the CHF admission rate.

**Diabetes Admission Rates** – related to: 119877204.1.1. Implementing 119877204.1.1 will increase primary care capacity. This increase in access to primary care may correlate with an increased percentage of the population who receive regular screenings and check-ups. As primary care capacity expands, providers will have more time to ensure best practices (e.g. patient follow-up) are followed concerning chronic disease management. This will improve diabetes prevention efforts and has the potential to reduce diabetes admission rates

**Behavioral Health and Substance Abuse Admission rate** – related to: 119877204.1.2, 119877204.1.3 The behavioral health measure stands to be improved upon by virtue of adding specialists in our service area that are experts in psychiatry. Like most rural communities, Del Rio is lacking an abundance of behavioral health specialists. If we are successful in bringing more resources to our community, reduced utilization of hospital inpatient and ER services is likely (i.e. potential reductions in the behavioral health and substance abuse admission rate). If recruiting a psychiatrist (119877204.1.2) is not feasible for our region, then accessing this specialty through a telemedicine program may occur (119877204.1.3).

**Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission rate** - related to: 119877204.1.1. Implementing 119877204.1.1 will increase primary care capacity. This increase in access to primary care may correlate with an increased percentage of the population who receive regular screenings and check-ups. As primary care capacity expands, providers will have more time to ensure best practices (e.g. patient follow-up) are followed concerning chronic disease...
management. This will improve COPD and Asthma prevention/management efforts and has the potential to reduce admission rates for these conditions.

**Hypertension Admission rate** - related to: 119877204.1.1 Implementing 119877204.1.1 will increase primary care capacity. This increase in access to primary care may correlate with an increased percentage of the population who receive regular screenings and check-ups. As primary care capacity expands, providers will have more time to ensure best practices (e.g. patient follow-up) are followed concerning chronic disease management. This will improve Hypertension prevention/management efforts and has the potential to reduce admission rates for these conditions.

**Pediatric Asthma** – related to: 119877204.1.1 Implementing 119877204.1.1 will increase primary care capacity. This increase in access to primary care may correlate with an increased percentage of the population who receive regular screenings and check-ups. As primary care capacity expands, providers will have more time to ensure best practices (e.g. patient follow-up) are followed concerning chronic disease management. This will improve Pediatric Asthma management efforts and has the potential to reduce admission rates for these conditions.

**Bacterial pneumonia immunization** – related to: 119877204.1.1 This project will provide greater access to primary care providers. This should increase the number of people who receive the bacterial pneumonia immunization.

**Influenza Immunization** – related to: 119877204.1.1 This project will provide greater access to primary care providers. This should increase the number of people who receive the influenza immunization.

**Valuation:**

When considering how to weigh the value of reporting and improving in five key areas: preventable admissions, 30-day readmissions, complications, patient experience and ED, we decided to weigh the five equally. In many respects, they are intertwined. As the team mobilizes resources to prepare for these projects, it will not be difficult to have the experts address multiple projects given their similarities (especially preventable admissions, readmissions and complications) at the same time. Patient experience ought to be a result of improved progress in each of these domains as well as with progress with our other Category 1 projects.

Progress across all of these initiatives will work to meet the needs of the community as identified by those asked of their opinion earlier this year. There is not any one of these Category 4 initiatives that substantially outweighs the other to think that a reasonable approach would not be to value them equally.

**Performing Provider:**

Performing Provider name: Val Verde Regional Medical Center (VVRMC)

TPI: 119877204

**Domain 2: Potentially Preventable Readmissions – 30 days**

**Description:**

**Relation of Category 4 Measures to VVRMC Category 1 & 3 Projects**

The overwhelming outcome of the Val Verde County/Del Rio community needs assessment was to
increase the supply of medical providers to our rural, medically-underserved community. As such, VVRMC has chosen DSRIP projects that will aim to expand access to care, both primary and specialty care. RD-2(30-day readmissions) ought to be favorably impacted—all other things equal—by virtue of having more primary care providers and specialists among the community. Better access to doctors we believe will move more care to the outpatient/clinic setting and reduce the stress placed on the hospital.

Several of the measures (HF readmission rate, diabetes readmission rate, COPD readmission rate and stroke readmission rate) are high-profile diagnoses that in Del Rio the primary care doctors are actively managing in the clinic. As clinic resources are expanded, and knowing that the prevalence of these diseases is so high in and around Del Rio, there will be a focus to more proactively manage these patient populations.

The behavioral health measure stands to be improved upon by virtue of adding specialists in our service area that are experts in psychiatry which is also tied to a Category 1 project. Like most rural communities, Del Rio is lacking an abundance of behavioral health specialists, and to the extent we are successful in bringing more resource to our community, reduced utilization of hospital inpatient and ER services is likely.

So often the cause of immediate readmission into the hospital is due to lack of coordination and follow-up after initial discharge from the hospital. For those patients being followed in the hospital clinic, there will be added focus on the hand off and care coordination to ensure that patients receive efficient and appropriate care as an outpatient in order to prevent unnecessarily returning to the hospital for readmission. If additional primary care providers create an environment which encourages and allows better access for preventative and more routine care, then readmissions stand the chance of being reduced.

**Expected Improvements in Category 4 Domains**

The expected improvements will be to reduce 30-day readmissions. In order to accomplish this goal, which is impacted by so many things, it will take great coordination between the clinic and the hospital to transition care back-and-forth.

The impact on these initiatives as well as our overall strategy to improve access to care we believe will significantly drive patient satisfaction with the healthcare system in Val Verde County. It is our desire that for members of our community who chose to seek healthcare elsewhere, which adds the cost of travel time at least 2½ hours in both directions, they will gain more confidence in the local system. For those patients who do not have the means to travel elsewhere and depend solely on VVRMC and the local clinics for their healthcare needs, we hope to educate them on how best to access the services and do an outstanding job while all are under our care either in the hospital or the clinic.

**Valuation:**

When considering how to weigh the value of reporting and improving in five key areas: preventable admissions, 30-day readmissions, complications, patient experience and ED, we decided to weigh the five equally. In many respects, they are intertwined. As the team mobilizes resources to prepare for these projects, it will not be difficult to have the experts address multiple projects given their similarities (especially preventable admissions, readmissions and complications) at the same time. Patient experience ought to be a result of improved progress in each of these domains as well as with progress with our other Category 1 projects.
Progress across all of these initiatives will work to meet the needs of the community as identified by those asked of their opinion earlier this year. There is not any one of these Category 4 initiatives that substantially outweighs the other to think that a reasonable approach would not be to value them equally.

### Performing Provider:
Performing Provider name: Val Verde Regional Medical Center (VVRMC)  
TPI: 119877204

**Domain 3: Potentially Preventable Complications**

**Description:**
The current DSRIP projects selected will have little or no impact on this reporting domain (RD-3). 119877204.1.2 may have some impact on PPCs if we are able to recruit specialists with very low risk-adjusted complication rates.

**Valuation:**
When considering how to weigh the value of reporting and improving in five key areas: preventable admissions, 30-day readmissions, complications, patient experience and ED, we decided to weigh the five equally. In many respects, they are intertwined. As the team mobilizes resources to prepare for these projects, it will not be difficult to have the experts address multiple projects given their similarities (especially preventable admissions, readmissions and complications) at the same time. Patient experience ought to be a result of improved progress in each of these domains as well as with progress with our other Category 1 projects.

Progress across all of these initiatives will work to meet the needs of the community as identified by those asked of their opinion earlier this year. There is not any one of these Category 4 initiatives that substantially outweighs the other to think that a reasonable approach would not be to value them equally.

### Performing Provider:
Performing Provider name: Val Verde Regional Medical Center (VVRMC)  
TPI: 119877204

**Domain 4: Patient-Centered Healthcare**

**Description:**

**Relation of Category 4 Measures to VVRMC Category 1 & 3 Projects**
VVRMC’s Category 3 project related to its Category 1 initiatives involves improving patient satisfaction. While this effort will be focused on clinic activity, clearly the mechanics of improving patient experience are consistent whether in the outpatient or inpatient setting. RD-4 (Patient-centered Healthcare) in large part is about tracking patient satisfaction (through HCAHPS) and showing progress toward set goals.

VVRMC is very focused on improving the patient experience both in the clinic as well as the inpatient setting.
**Expected Improvements in Category 4 Domains**

The impact on these initiatives as well as our overall strategy to improve access to care we believe will significantly drive patient satisfaction with the healthcare system in Val Verde County. It is our desire that for members of our community who chose to seek healthcare elsewhere, which adds the cost of travel time at least 2 ½ hours in both directions, they will gain more confidence in the local system. For those patients who do not have the means to travel elsewhere and depend solely on VVRMC and the local clinics for their healthcare needs, we hope to educate them on how best to access the services and do an outstanding job while all are under our care either in the hospital or the clinic.

**Valuation:**

When considering how to weigh the value of reporting and improving in five key areas: preventable admissions, 30-day readmissions, complications, patient experience and ED, we decided to weigh the five equally. In many respects, they are intertwined. As the team mobilizes resources to prepare for these projects, it will not be difficult to have the experts address multiple projects given their similarities (especially preventable admissions, readmissions and complications) at the same time. Patient experience ought to be a result of improved progress in each of these domains as well as with progress with our other Category 1 projects.

Progress across all of these initiatives will work to meet the needs of the community as identified by those asked of their opinion earlier this year. There is not any one of these Category 4 initiatives that substantially outweighs the other to think that a reasonable approach would not be to value them equally.

**Performing Provider:**

Performing Provider name: Val Verde Regional Medical Center (VVRMC)

TPI: 119877204

**Domain 5: Emergency Department**

**Description:**

The current DSRIP projects selected will have little or no impact on this reporting domain (RD-5).

**Valuation:**

When considering how to weigh the value of reporting and improving in five key areas: preventable admissions, 30-day readmissions, complications, patient experience and ED, we decided to weigh the five equally. In many respects, they are intertwined. As the team mobilizes resources to prepare for these projects, it will not be difficult to have the experts address multiple projects given their similarities (especially preventable admissions, readmissions and complications) at the same time. Patient experience ought to be a result of improved progress in each of these domains as well as with progress with our other Category 1 projects.

Progress across all of these initiatives will work to meet the needs of the community as identified by those asked of their opinion earlier this year. There is not any one of these Category 4 initiatives that substantially outweighs the other to think that a reasonable approach would not be to value them equally.
### Category 4: Population-Focused Measures

*Val Verde Regional Medical Center (VVRMC)/119877204*

<table>
<thead>
<tr>
<th>Capability to Report Category 4</th>
<th>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</th>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 1: Potentially Preventable Admissions (PPAs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
</tr>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
</tr>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
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</table>

<table>
<thead>
<tr>
<th>Domain 3: Potentially Preventable Complications (PPCs)</th>
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<tbody>
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<td>Planned Reporting Period: 1 or 2</td>
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<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
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<thead>
<tr>
<th>Domain 4: Patient Centered Healthcare</th>
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<tr>
<td>Patient Satisfaction – HCAHPS</td>
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<td>Planned Reporting Period: 1 or 2</td>
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<tr>
<th>Medication Management</th>
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<td>Planned Reporting Period: 1 or 2</td>
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<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
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### Domain 5: Emergency Department

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</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$70,540</td>
<td>$75,528</td>
<td>$82,075</td>
</tr>
</tbody>
</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

**Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**

| Domain 6 - Estimated Maximum Incentive Amount | $n/a | $n/a | $n/a |

### Grand Total Payments Across Category 4

|                          | $152,113 | $352,700 | $377,640 | $410,375 |
Section VI. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments has certified the following:

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

Signed certifications are included for these Performing Providers:

- Baptist Health System
- Bluebonnet Trails Community Services
- Camino Real Community Services
- Center for Health Care Services
- Children’s Hospital of San Antonio
- CHRISTUS Santa Rosa Health System
- Clarity Child Guidance Center
- Community Medicine Associates
- Connally Memorial Medical Center
- Dimmit Regional Hospital
- Frio Regional Hospital
- Guadalupe Regional Medical Center
- Hill Country Memorial Hospital
- Hill Country Mental Health and Developmental Disabilities Center
- Medina Regional Hospital
- Methodist Hospital
- Nix Health Care System
- Peterson Regional Medical Center
- San Antonio Metropolitan Health District
- San Antonio State Hospital
- South Texas Regional Medical Center
- Southwest General Hospital
- Texas Center for Infectious Disease
- University Hospital
- University of Texas Health Science Center at San Antonio
- Uvalde Memorial Hospital
- Val Verde Regional Medical Center
Section VII. Addendums

Region 6 is submitting the following addendums

A. List of Stakeholder Meetings
B. Region 6 Website
C. Supporting Documentation Related to Public Engagement
D. List of DSRIP Projects
E. Affiliation Agreements and Certifications
F. Checklist and Response to HHSC Feedback
### Addendum A: List of Stakeholder Meetings

Numerous meetings and calls were held within RHP 6 to discuss and collaborate on the waiver. The list below documents some of these key meetings.

<table>
<thead>
<tr>
<th>Date(s) and location of Meeting</th>
<th>Attendees</th>
<th>Purpose of Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/5/12</td>
<td>University Health System - George B. Hernandez, Jr.</td>
<td>Discuss 1115 waiver</td>
</tr>
<tr>
<td></td>
<td>Methodist Healthcare System - Jamie Wesolowski</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baptist Health System - Graham Reeve</td>
<td></td>
</tr>
<tr>
<td>5/15/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Antonio</td>
<td>University Health System – Dr. Sally Taylor</td>
<td>Discuss behavioral health projects for the 1115 waiver</td>
</tr>
<tr>
<td></td>
<td>Bexar County – Aurora Sanchez</td>
<td></td>
</tr>
<tr>
<td>3/4/12</td>
<td></td>
<td>Update stakeholders on 1115 waiver</td>
</tr>
<tr>
<td>San Antonio</td>
<td>HHSC Regional Stakeholder Meeting</td>
<td></td>
</tr>
<tr>
<td>3/21/12</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden</td>
<td>Discussion of potential DSRIP projects</td>
</tr>
<tr>
<td>San Antonio</td>
<td>Peterson Regional Medical Center - Pat Murray</td>
<td></td>
</tr>
<tr>
<td>3/28/2012</td>
<td></td>
<td>Discuss county involvement in project and potential needs.</td>
</tr>
<tr>
<td>Kerrville</td>
<td>Peterson Regional Medical Center – Bob Walther</td>
<td></td>
</tr>
<tr>
<td>3/29/12</td>
<td>Kerr County - Rosa Lavender, Indigent Health Program</td>
<td></td>
</tr>
<tr>
<td>Kerrville</td>
<td>University Health System</td>
<td>Discuss project collaboration between UHS and CentroMed</td>
</tr>
<tr>
<td>4/6/12</td>
<td>• George B. Hernandez, Jr.</td>
<td></td>
</tr>
<tr>
<td>4/24/12</td>
<td>• Dr. Bryan Alsip</td>
<td></td>
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<tr>
<td>5/7/12</td>
<td>CentroMed FQHC – Dr. Ernesto Gomez</td>
<td></td>
</tr>
<tr>
<td>7/17/12</td>
<td></td>
<td>Discuss project collaboration between UHS and CentroMed</td>
</tr>
<tr>
<td>8/22/12</td>
<td></td>
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<tr>
<td>9/26/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/11 – 4/18 Phone calls</td>
<td>University Health System</td>
<td>Waiver education and discussion of planning processes</td>
</tr>
<tr>
<td>San Antonio</td>
<td>• Carol Huber</td>
<td></td>
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<tr>
<td></td>
<td>McMullen County Indigent Care – Jayne Varga</td>
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<td></td>
<td>Medina Healthcare System – Janice Simons</td>
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<td></td>
<td>Peterson Regional Medical Center – Bob Walther</td>
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<td></td>
<td>Guadalupe Regional Medical Center – Robert Haynes</td>
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<td></td>
<td>Bluebonnet Trails Community Services – Andrea Richardson</td>
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<td></td>
<td>Center for Health Care Services – Charlie Boone</td>
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<td></td>
<td>Uvalde Memorial Hospital – Jim Buckner</td>
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<td></td>
<td>Real County Judge Garry Merritt</td>
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<td></td>
<td>Frio Regional Hospital – Michael Thompson</td>
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<tr>
<td></td>
<td>Comal County Judge Sherman Krause</td>
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<tr>
<td>Date</td>
<td>Location Auditor</td>
<td>Participants</td>
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<tr>
<td>4/19/12</td>
<td>Kerrville</td>
<td>Peterson Regional Medical Center – Bob Walther, Kerr County MHDD (representative)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussed ideas PRMC could assist MHDD with to meet the needs of Kerr County’s mental health population.</td>
</tr>
<tr>
<td>4/20/12</td>
<td>San Antonio</td>
<td>University Health System - Dr. Bryan Alsip, Carol Huber, Alamo Area Council of Governments - Martha Spinks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss 1115 waiver</td>
</tr>
<tr>
<td>4/24/12</td>
<td>Uvalde</td>
<td>Uvalde Memorial Hospital Board - Dr. Hector Gonzales, Dr. G.V. Gaitonde, Medford Keath, Jr., Hector V. Garcia, William Kessler, Jr., Raul Zamora, Mario Cruz, Dr. Cliff White, Jim Buckner, Jeanne Leake, Valerie Lopez, Michalle Helmuth</td>
</tr>
<tr>
<td>6/26/12</td>
<td></td>
<td>Uvalde Memorial Hospital Board Meeting, open to the public, discussed possibilities for collaborative DSRIP projects with surrounding hospitals.</td>
</tr>
<tr>
<td>7/24/12</td>
<td></td>
<td>Discussed a primary care physician recruitment DSRIP project with possible collaboration with Our Health, Inc. (local FQHC). One of the goals of the project discussed was reducing ER visits.</td>
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<tr>
<td></td>
<td></td>
<td>Discussed a regional mobile digital mammography program covering 11 nearby counties as a possible DSRIP funded project.</td>
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<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>4/27/12</td>
<td>San Antonio</td>
<td>University Health System - George B. Hernandez, Jr. Southwestern General Hospital - Craig Desmond</td>
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<td>7/31/12</td>
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<tr>
<td>04/30/12</td>
<td>Hondo, TX</td>
<td>Medina Healthcare System Board Meeting</td>
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<tr>
<td></td>
<td></td>
<td>• Steve Hackbeil</td>
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<td></td>
<td></td>
<td>• Rita Vance</td>
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<td></td>
<td></td>
<td>• Judy Winkler</td>
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<td></td>
<td>• Tim Hardt</td>
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<td></td>
<td></td>
<td>• Tony B. Johnson</td>
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<td></td>
<td>• Carlton “Corky” E. Young, DVM</td>
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<td>• William “Bill” Bain</td>
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<td>• Janice Simons</td>
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<td>• Kevin Frosch</td>
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<td></td>
<td></td>
<td>• Denise McWilliams</td>
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<td></td>
<td></td>
<td>• Brian Petter</td>
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<tr>
<td></td>
<td></td>
<td>• Geoff Crabtree</td>
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<tr>
<td>5/2/12</td>
<td>San Antonio</td>
<td>San Antonio Metropolitan Health District, San Antonio City Council and Executive Staff</td>
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<td>Center for Health Care Services</td>
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<tr>
<td>7/13/12</td>
<td></td>
<td>• Mark Carmona</td>
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<tr>
<td>8/25/12</td>
<td></td>
<td>• Cynthia Martinez</td>
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<tr>
<td>9/28/12</td>
<td></td>
<td>University Health System</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dr. Sally Taylor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carol Huber</td>
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<tr>
<td>5/16/2012</td>
<td>San Antonio</td>
<td>Center for Health Care Services - Mark Carmona University Health System - Dr. Alsip</td>
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<td>5/17/ 2012</td>
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<td>Center for Health Care Services - Mark Carmona Bexar County Official - Judge Specia</td>
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<td>Center for Health Care Services</td>
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<td></td>
<td></td>
<td>• Charlie Boone</td>
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<td></td>
<td></td>
<td>• Mark Carmona</td>
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<tr>
<td>5/25/12</td>
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<td>Camino Real Board of Trustees</td>
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<tr>
<td>6/15/12</td>
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<tr>
<td>7/20/12</td>
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<td>8/17/12</td>
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<tr>
<td>9/21/12</td>
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</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>6/13/12</td>
<td>San Antonio</td>
<td>Bexar County - Aurora Sanchez Clarity Child Guidance Center</td>
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<tr>
<td></td>
<td></td>
<td>Chris Bryan</td>
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<td></td>
<td></td>
<td>Rebecca Helterbrand</td>
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<td>6/05/12</td>
<td>San Antonio</td>
<td>University Health System</td>
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<td></td>
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<td>Dr. Bryan Alsip</td>
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<td>Dr. Sally Taylor</td>
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<td>Carol Huber</td>
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<td>Center for Health Care Services</td>
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<td>Fred Hines</td>
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<td>Chris Bryan</td>
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<td>Rebecca Helterbrand</td>
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<td>6/5/12</td>
<td>San Antonio</td>
<td>University Health System – Carol Huber</td>
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<td>Hill Country MHDD – Linda Werlein</td>
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<td>6/5/2012</td>
<td>San Antonio, Texas</td>
<td>Center for Health Care Services - Zaida Yzaguirre, University of Texas Health Science Center</td>
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<td>Department of State Health Services</td>
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<td>Community stakeholders</td>
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<td>06/08/12</td>
<td>Hondo</td>
<td>Frio Regional Hospital - Michael Thompson</td>
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<td></td>
<td>Uvalde Memorial Hospital - Jeanne Leake</td>
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<td>Uvalde Memorial Hospital - Trudy McPherson</td>
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<td></td>
<td></td>
<td>Drs. Matt Windrow, Zach Windrow, John Meyer and Miles Hutson</td>
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<td></td>
<td>Methodist Healthcare System - Michael John</td>
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<td></td>
<td></td>
<td>Medina Regional Hospital - Janice Simons</td>
</tr>
<tr>
<td>6/12/2012</td>
<td>Fredericksburg</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden</td>
</tr>
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<td></td>
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<td>Hill Country Memorial Hospital - Mike Williams</td>
</tr>
<tr>
<td>6/12/12</td>
<td>Phone call</td>
<td>University Health System - Carol Huber</td>
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<td></td>
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<td>Vida Y Salud FQHC (Zavala County) - Carlos Moreno</td>
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<tr>
<td>6/14/2012</td>
<td>San Antonio</td>
<td>Center for Health Care Services - Cynthia Martinez</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of State Health Services - Nettie Karosi</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Event Description</td>
</tr>
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<tr>
<td>6/14/12</td>
<td>San Antonio</td>
<td>Bexar County Mental Health Taskforce Meeting</td>
</tr>
<tr>
<td>6/14/12</td>
<td>Camino Real Planning Network Advisory Committee</td>
<td>Planning for DSRIP projects across 9 county area</td>
</tr>
<tr>
<td>6/15/2012</td>
<td>Center for Health Care Services</td>
<td>Discussion on IGT, shared waiver project, impact to CRJ system and hospitalization system.</td>
</tr>
<tr>
<td>6/19/12</td>
<td>Phone</td>
<td>Carol Huber, Communicare and Southwest Texas Network - Dr. Rudy Urby</td>
</tr>
<tr>
<td>6/19/12</td>
<td>Uvalde</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden Uvalde Memorial Hospital, Jim Buckner</td>
</tr>
<tr>
<td>6/22/2012</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden Medina Regional Hospital - Janice Simmons</td>
<td>Discussion of potential DSRIP projects</td>
</tr>
<tr>
<td>6/22/2012</td>
<td>Camino Real Vida y Salud – Dr. Carlos Moreno, CEO Dimmit Regional Hospital, Ernesto Flores, Executive Director</td>
<td>Discuss 1115 waiver</td>
</tr>
<tr>
<td>6/25/2012</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden Val Verde Regional Medical Center - Mark Strode</td>
<td>Discussion of potential DSRIP projects</td>
</tr>
<tr>
<td>6/28/12</td>
<td>Clarity Child Guidance Center Board Meeting (board members represent our community at large and stakeholders)</td>
<td>Training on 1115 Waiver and discussion on Clarity Child Guidance Center project alignment</td>
</tr>
<tr>
<td>06/26/2012</td>
<td>Service Organization of San Antonio (SOSA) Board Meeting</td>
<td>The Directors discussed the next steps necessary to participation in RHP6 of the 1115 Waiver program.</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>07/2012</td>
<td>Hondo</td>
<td>Medina Regional Hospital - Janice Simons, Pam Muennink, Medina County Health Nurse, Medina County Health Unit Staff</td>
</tr>
<tr>
<td>7/9/12</td>
<td>San Antonio</td>
<td>University Health System - Dr. Bryan Alsip, Carol Huber, Natalia Mayor Ruby Vera, City Administrators</td>
</tr>
<tr>
<td>7/17/2012</td>
<td>San Antonio</td>
<td>Center for Health Care Services - Cynthia Martinez, Bluebonnet Trails Community Services - Charlie Boone</td>
</tr>
<tr>
<td>7/23/12</td>
<td>Uvalde</td>
<td>Uvalde Memorial Hospital - Jim Buckner, Frio Regional Hospital - Michael Thompson, Dimmit County Memorial Hospital - Ernest Flores, Medina Regional Hospital - Janice Simons, Matt Kempton, Consultant</td>
</tr>
<tr>
<td>7/24/2012</td>
<td>Kerrville</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden, Hill Country Citizen's Advisory Committee</td>
</tr>
<tr>
<td>7/31/12</td>
<td>University Health System</td>
<td>Carol Huber, UTHSCSA Dental School faculty</td>
</tr>
<tr>
<td>08/06/2012</td>
<td>Austin</td>
<td>Baptist Health System - Linda Kirks, University Health System - George B. Hernandez, Jr., Peggy Deming, Bill Bedwell, Patrick Carrier, Center for Health Care Services – Leon Evans, Peterson Regional Medical Center - Bob Walther, UTHSCSA - Gabe Hernandez</td>
</tr>
<tr>
<td>8/10/12</td>
<td>Hill Country Memorial Hospital</td>
<td>Mark Jones, Peterson Regional Medical Center – Bob Walther</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
</tr>
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<td>------------</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>8/14/2012</td>
<td>New Braunfels</td>
<td>Hill Country Mental Health and Development Disabilities Center – David Weden</td>
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<td>Christus Santa Rosa New Braunfels - Jim Wesson</td>
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<tr>
<td>8/21/12</td>
<td>Phone</td>
<td>Peterson Regional Medical Center - Bob Walther</td>
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<td>Hill Country Memorial Hospital - Mark Jones</td>
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<td>Hill Country Memorial Hospital - Janice Menking</td>
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<td></td>
<td></td>
<td>Hill Country Memorial Hospital - Emily Padula</td>
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<tr>
<td>9/11/2012</td>
<td>San Antonio</td>
<td>Baptist Health System – Linda Kirks, CFO</td>
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<td>Methodist Health System - N Meadows, CFO</td>
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<tr>
<td>9/18/12</td>
<td>San Antonio</td>
<td>CHRISTUS Santa Rosa Health System - Pat Carrier, CEO,</td>
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<td></td>
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<td>Mayor Julian Castro</td>
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<td>USAA - Gen. Joe Robles, CEO</td>
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<td>Rackspace - Graham Wesson, CEO</td>
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<td>Zachary Construction - Bartell Zachary, CEO</td>
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<td>McCombs Enterprises - Red McCombs, CEO</td>
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<td>Beldon Roofing - Mike Beldon, CEO</td>
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<tr>
<td>9/22/12</td>
<td>San Antonio</td>
<td>CHRISTUS Santa Rosa Health System</td>
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<tr>
<td>10/3/12</td>
<td>San Antonio</td>
<td>Pat Carrier</td>
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<td></td>
<td></td>
<td>Various physicians (Family Practice &amp; Pediatricians)</td>
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<td>Various members of the community (Approximately 20 people)</td>
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<tr>
<td>10/09/2012</td>
<td>San Antonio</td>
<td>University Health System</td>
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<td>• George B. Hernandez, Jr.</td>
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<td>• Ted Day</td>
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<td>CHRISTUS Santa Rosa Health System – S. Barnett</td>
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<td>Baptist Health System - Linda Kirks</td>
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<td>Methodist Health System – Nancy Meadows</td>
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<td>Methodist Health System – T. Carr</td>
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<td>10/15/2012</td>
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<td>Baptist Health System - Linda Kirks, CFO</td>
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<td>Methodist Health System – Nancy Meadows</td>
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<td>Methodist Health System – Carla Davila</td>
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<td>CHRISTUS Santa Rosa Health System – P. Mote</td>
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<tr>
<td>8/1/2012</td>
<td>Austin</td>
<td>Center for Health Care Services</td>
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<td>Texas Council Risk Management Fund</td>
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<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>8/14/2012</td>
<td>San Antonio</td>
<td>Bexar County - Judge Kazen Center for Health Care Services - Leon Evans</td>
</tr>
<tr>
<td>10/4/2012</td>
<td>San Antonio</td>
<td>Center for Health Care Services - Leon Evans</td>
</tr>
<tr>
<td>November 2011, March 2012, August 2012</td>
<td>Del Rio, Texas</td>
<td>Del Rio Lion’s Club, Del Rio Chamber of Commerce</td>
</tr>
<tr>
<td>9/4/12</td>
<td>Fredericksburg</td>
<td>Hill Country Memorial Hospital • Michael Williams • Mark Jones • Jayne Pope • Debye Wallace • Holly Schmidt • Monty Mohon • Robert Murray Community Members</td>
</tr>
<tr>
<td>9/14/12</td>
<td>San Antonio</td>
<td>University Health System San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>9/17/12</td>
<td>Fredericksburg</td>
<td>Hill Country Memorial Hospital - Emily Padula The Good Samaritan Center - John Willome</td>
</tr>
<tr>
<td>9/19/2012</td>
<td></td>
<td>University Health System • Ted Day • Carol Huber Healthcare Access San Antonio – Gijs Van Oort</td>
</tr>
<tr>
<td>10/4/12</td>
<td>Kerrville</td>
<td>Representatives from: Peterson Regional Medical Center City of Kerrville Mayor Hill Country Community Journal Reporter Tivy High School PTO</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>10/2/12</td>
<td>San Antonio</td>
<td>UTHSCSA Department of OB/GYN, Healthy Futures, Bexar County Health Collaborative, Joven, San Antonio Metropolitan Health District</td>
</tr>
<tr>
<td>10/1/12</td>
<td>San Antonio, TX</td>
<td>San Antonio Metropolitan Health District, City of San Antonio Planning Department, City of San Antonio Public Works Department, City of San Antonio Parks Department, City of San Antonio Office of Sustainability, San Antonio Public Library, City of San Antonio Capital Improvement Management Services Department, Bexar County Metropolitan Planning Organization, San Antonio Housing Authority</td>
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<tr>
<td>11/7/2012</td>
<td>San Antonio</td>
<td>Region 6 Public Meeting</td>
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<tr>
<td>12/3/2012</td>
<td>San Antonio</td>
<td>University Health System – Ted Day Methodist Healthcare Ministries Performing Provider representatives</td>
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<tr>
<td>12/4/2012</td>
<td>Phone</td>
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<tr>
<td>12/13/2012</td>
<td>Webinar</td>
<td>Region 6 Public Meeting</td>
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</table>
Addendum B: Region 6 Website

The press release marking the launch of www.TexasRHP6.com and screenshots from the Website are provided below.


University Health System launches Regional Healthcare Partnership website

(SAN ANTONIO, TX - May 3, 2012) University Health System has launched a website to provide a resource for information regarding the Texas Healthcare Transformation and Quality Improvement Program, commonly referred to as the Medicaid 1115 Waiver. The site, TexasRHP6.com, will be updated regularly with news and developments related to the Waiver and the establishment of a new Regional Healthcare Partnership (RHP) for Region 6.

Through the website, hospitals participating in the Region 6 RHP, and others interested in the new program, will be able to sign up for email updates, send comments, and connect with other hospital partners. In the near future, this website will be expanded to collect data, compile proposed healthcare improvement projects and produce a regional plan.

RHPs are a key component of the Medicaid 1115(a) waiver approved by The Centers for Medicare and Medicaid (CMS) on December 12, 2011. According to the Texas Health and Human Services Commission (HHSC), the Texas Healthcare Transformation and Quality Improvement Program “allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements and directs more funding to hospitals that serve large numbers of uninsured patients.”

HHSC is currently finalizing the geographic boundaries for each RHP, which will be directed by a public hospital or local governmental entity. The lead or “anchor” entity is also responsible for coordinating with participating hospitals in the development of the region’s RHP plan. The plan will identify participating partners, community needs, proposed projects and funding distribution.
**To download the current draft of the proposed RHP Plan, click here.**

The Texas Health and Human Services Commission (HHSC) has received federal approval of a waiver that allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements, and directs more funding to hospitals that serve large numbers of uninsured patients.

HHSC has established geographic boundaries for new Regional Healthcare Partnerships (RHP). Each RHP will develop a plan that will identify the participating partners, community needs, proposed projects and funding distribution.

RHP 6 is anchored by University Health System and includes the following counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.
Message from University Health System CEO

University Health System is honored to be the anchor for RHP 6. It is our pleasure to coordinate with the UT Health Science Center at San Antonio, our hospital partners and other stakeholders to transform healthcare in our 20-county region. Through this waiver, we have the opportunity to work together to make significant progress toward the Triple Aim goals of assuring patients receive high-quality and patient-centered care, in the most cost-effective ways.

We strive to keep this site up to date with information regarding Medicaid 1115 waiver developments in our region and throughout the state. We hope you “bookmark it” and find it to be a useful resource as you work on your organization’s DSRIP plans. Please don’t hesitate to contact me or members of our RHP team if you have any questions or suggestions.

Best Regards,

[Signature]

George B. Hernández, Jr.
President and Chief Executive Officer
George.Hernandez@uhs-sa.com
210.358.2000

Peggy Deming
Executive Vice President
Chief Financial Officer
Peggy.Deming@uhs-sa.com
210.358.2101

Christann Vasquez
Executive Vice President
Chief Operating Officer
Christann.Vasquez@uhs-sa.com
210.358.1036

Bryan Alsip, MD, MPH
Executive Vice President
Chief Medical Officer
Bryan.Alsip@uhs-sa.com

Ted Day
Vice President
Strategic Planning and Business Development
Ted.Day@uhs-sa.com
Join us for a Webinar on December 13

Space is limited. Reserve your Webinar seat now at:
https://www2.potommeeting.com/register729551250

During this event, representatives from University Health System will provide an updated summary of the RHP Plan which will be delivered to the Texas Health and Human Services Commission as part of the Texas Health Care Transformation and Quality Improvement Program (CUS 1115 waiver).

Continue reading →

Baseline/outcome teleconference

Baseline/outcome teleconference: The teleconference on baselines and outcomes will be on Thursday, Nov. 1 from 2 – 4. Dr. Betsy Shenkman, our Texas Medicaid EORO quality expert, will take questions from all stakeholders during this call, so feel free to send the access information to other interested parties. We will have many lines, but since there is a lot of interest, we encourage you to call from a single location as you are able to ensure access for all.

Dr. Shenkman will first address questions emailed to the waiver mailbox,
TXHealthcareTransformation@hhsc.state.tx.us,

by COB Wednesday, Oct. 31. Please precede your subject line on your email with “Baseline/outcome question” so we can easily identify your questions.

To access the teleconference: Dial 877-331-7677. You will be placed directly into conference.
State Waiver Resources

HHSC has posted information about the waiver on its [website](#). You can also access selected materials below:

**Medicaid 1115 Waiver**

- [CMS Approval Letter and Standard Terms and Conditions](#)
- [Transformation Waiver Terminology](#)

**Regional Healthcare Partnerships**

Regional Healthcare Partnerships are locally-developed collaborations that fund the state share of all waiver payments in a partnership. Counties and other entities providing state share will determine how their funds are used in the Regional Healthcare Partnership consistent with waiver requirements. Each Intergovernmental Transfer (IGT) provider controls its own fund use and commitments, provided that participating healthcare providers that may be affiliated with the transferring entity adequately document levels of uncompensated care or meet required performance goals.

- [RHP map](#) - final as of August 7, 2012
- [Contact information](#) - final as of May 30, 2012
- [FINAL RHP Plan Template](#) - HHSC has finalized this template, which all RHPs will be responsible for completing and submitting to HHSC. HHSC also has developed a companion document and RHP plan checklist that will help RHPs in the development of their RHP plan. This companion document will be updated as new resources become available.

**Delivery System Reform Incentive Pool**

HHSC released the [FINAL Regional Healthcare Partnership (RHP) Planning Protocol (DSRIP Menu)](#) which was approved by CMS on September 28, 2012.

**Waiver Funding**

These [guidelines](#) include principles and examples of potential intergovernmental transfers under the 1115 waiver. HHSC intends for RHPs to use this document as high level guidance, not an exhaustive list of possible IGT scenarios.
Request Email Updates

Complete the form below to receive email updates from RHP6. You may also request email updates from HHSC.

First Name: ___________________________ (required)
Last Name: ____________________________ (required)
Email: __________________________________ (required)
Organization: ___________________________
Title: __________________________________
Enter the text shown: BKS5

Send
Partners

University Health System is pleased to partner with the following hospitals, local mental health authorities, and academic health science centers in Region 6:

Atascosa County
- South Texas Regional Medical Center
- Camino Real Community Services

Bandera County
- Hill Country Mental Health & Developmental Disabilities Centers

Bexar County
- University Health System
- Baptist Health System
- Methodist Healthcare
- CHRISTUS Santa Rosa Health System
- Nix Hospital
- Southwest General Hospital
- University of Texas Health Science Center San Antonio
- The Center for Healthcare Services
- Clarity Child Guidance Center
- Community Medicine Associates
Comments & Feedback

We value your comments and ideas as we develop our Regional Healthcare Partnership. To submit general comments or questions, please use the form below. To submit comments related to the proposed RHP Plan, click here.

First Name: ________________________________ (required)
Last Name: ________________________________ (required)
Email: ________________________________ (required)
Organization: ________________________________
Title: ________________________________
Subject: ________________________________
Comments: ____________________________________________________________________________

Enter the text shown: Q A Z K

Send
Addendum C: Supporting Documentation Related to Public Engagement

The communications below include press releases and emails to Region 6 stakeholders who registered online at www.TexasRHP6.com to receive email updates. Numerous additional emails were sent directly to Performing Providers with specific instructions related to submission of documents for inclusion in the RHP Plan. A letter from the Bexar County Medical Society in support of the Regional Plan is also included in this addendum.

July 9, 2012

Proposed DSRIP Projects

Performing Providers interested in participating in the Delivery System Reform Incentive Payment (DSRIP) Pool are asked to submit proposed projects using the DSRIP Template. Proposed projects must be emailed by Wednesday, July 18, 2012, to carol.huber@uhs-sa.com. Please note that this template was designed based on the most recent release of protocols from HHSC and is subject to change as we receive further direction.

RHP Planning Summit

HHSC has announced a RHP Planning Summit in August. Each Region was allocated a limited number of invitations by HHSC. Due to this limited seating, HHSC will broadcast the conference online so people not able to attend in-person can watch presentations, hear discussions, and submit questions through an online chat window.

The following organizations will represent Region 6 at the meeting:

- University Health System (Region 6 Anchor)
- University of Texas Health Science Center at San Antonio
- Center for Health Care Services
- CHRISTUS Santa Rosa Health System
- Baptist Health System
- Methodist Healthcare
- South Texas Regional Medical Center (Atascosa County)
- Uvalde Memorial Hospital
- Peterson Regional Medical Center (Kerr County)
- Val Verde Regional Medical Center

Learn more about the RHP Planning Summit
July 9, 2012, continued.

**Updated RHP Planning Protocol released**

HHSC has posted the revised DSRIP Menu – now referred to as the Regional Healthcare Partnership (RHP) Planning Protocol. Learn more...

**Public Comment Requested**

HHSC seeks public comment on the revised Program Funding and Mechanics (PFM) Protocol. Comments are due Friday, July 13.

- Download Program Financing and Mechanics Protocol
- Download the Public Comments Form

**Upcoming Webinars**

Program Funding and Mechanics (PFM) Protocol Webinar  
Tuesday, July 10th, 10 to 11:30 a.m. Central Time.

Delivery System Reform Incentive Payments (DSRIP) RHP Planning Protocol Webinar  
Wednesday, July 11th, 10 to 11:30 a.m. Central Time.

For access information, visit our Upcoming Webinar page.

**For More Information**

Please visit www.TexasRHP6.com often for all Region 6 updates.

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July 19, 2012

University Health System wishes to thank those of you who submitted your DSRIP projects yesterday. We are working to compile the proposed projects for inclusion in the draft RHP plan and will contact you individually if we need further clarification or documentation for your submissions. The RHP Planning Protocol and the Program Financing and Mechanics Protocol remain subject to change until CMS approves them. Performing Providers will have an opportunity to modify their submissions based on any forthcoming revisions.

We understand that the 1115 waiver is a complicated process which continues to develop. As the RHP 6 Anchor, we are committed to providing you with information and timely guidance as we receive it from HHSC. Please continue to check our website, www.TexasRHP6.com, for updates. If you have any questions, you may contact us at rhp6waiver@uhs-sa.com or call Carol Huber at 210 358 8792.

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Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/
Two announcements have been posted to www.TexasRHP6.com:

Pre-RHP Planning Summit Webinar: Friday, August 3, 1:30 - 3 p.m.

During Friday’s webinar, HHSC will discuss changes to the Program Funding and Mechanics (PFM) protocol, address public comments received on the PFM protocol, and provide a brief overview of the Delivery System Reform Incentive Payment (DSRIP)/RHP Planning Protocol. HHSC is continuing to negotiate the details of the PFM and RHP Planning Protocols with CMS. This information will provide a helpful foundation for the RHP Summit.

For more information: www.TexasRHP6.com/pre-rhp-planning-summit-webinar-friday-august-3/

RHP Summit Webcast Information Now Available

The HHSC Regional Healthcare Partnership (RHP) Planning Summit is scheduled for August 7 - 8, 2012. The agenda and webcast information are now available.

For more information: www.TexasRHP6.com/rhp-summit-webcast-information-now-available/

Please send questions and requests to unsubscribe to osrl.huber@uha-aa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments/feedback/
RHP Planning Summit

The RHP Planning Summit was held August 7-8. HHSC will make the summit presentations available on its website. While we await the official postings, we have made scanned copies of the materials available here for your review.

Download the RHP Planning Summit Materials

Uncompensated Care (UC) Tool

HHSC’s Rate Analysis Department website has been updated to include information about the 1115 waiver, including the newly posted Uncompensated Care (UC) tool.

The tool must be completed by all hospitals claiming UC payments for DY 1 and submitted to HHSC no later than September 10, 2012.

Next Steps

HHSC and CMS continue to negotiate many of the 1115 waiver details. While HHSC has extended the deadline for RHP Plans, RHP 6 remains committed to submitting its plan as soon as possible pending receipt of the next round of documents due to the Regions from HHSC. This will maximize time for HHSC to review and provide feedback on our region’s plan prior to its submission to CMS. University Health System will continue to post updates to our dedicated website: www.TexasRIP6.com.

Performing Providers and other stakeholders are advised to be on alert for the latest announcements and continue to refine your DSRIP proposals accordingly.

Please send questions and requests to unsubscribe to carol.huber@uhhsa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrip6.com/comments-feedback/
Summary of August 17 Anchor Call

HHSC held an 1115 Waiver Anchor Call on Friday, August 17.

Main issues included:

- UC tool
- Proposed dates for release of PFM and RHP Planning Protocol documents
- Changes to RHP Plan as relates to Category 3
- Issues still being negotiated with CMS

Visit our Web site to view the summary documents.

August 28, 2012

Updated PFM Protocol Released

HHSC has released the latest draft of the Program Financing and Mechanics Protocol. Key changes are highlighted within the document. In general, please note:

- Category 4 reporting will begin in DY 3 for the PPA and PFR domains, and in DY 4 for the PPC domain and continue through DY 5.
- A learning collaborative will be conducted annually during DYs 3-5 to share learning, experiences, and best practices acquired from the DSRIP program across the State.
- RHPs must meet participation requirements for major safety net hospitals.
- RHPs must meet participation requirements for non-profit and other private hospitals.
- The funding allocation among categories has changed to give more weight to category 3 in DYs 3-5.
- Pass 1 DSRIP Allocations for Hospital Performing Providers are now available.

Updated RHP Planning Protocol Released

HHSC has released updated drafts for Category 1 and Category 2. These drafts do not include the behavioral health project area. We anticipate this area will be added back in a future release.

Delayed Implementation of UC Tools

The Texas Hospital Uncompensated Care Tool (TXHUC) and the Texas Physician Uncompensated Care Tool (TXPUC) and instructions for both tools are being removed from the Health and Human Services Commission’s (HHSC’s) Rate Analysis Department website. The TXHUC and TXPUC tools are being revised and will be reposted on the website during the first week in September.

For more information, click http://www.texasrhp6.com/notice-of-delayed-implementation-of-uc-tools/
Advanced UC Payments to Hospitals

To avoid potential financial hardship resulting from delayed implementation of the UC tool, HHSC will make advanced uncompensated-care (UC) payments to most hospitals participating in the 1115 waiver. The advanced UC payments are considered interim and subject to reconciliation once each hospital’s final UC limit is determined. HHSC is currently working to process advanced UC payments for hospitals for which HHSC has already calculated a 2012 hospital-specific limit (HSL) or transition cap. These advanced UC payments will likely be processed in October, 2012, and will be reconciled to the UC maximum payment amount calculated from the TXHUC after it is submitted. More information on advanced payments will be forthcoming in September.

For more information, click http://www.texasrhp6.com/notice-of-delayed-implementation-of-uc-tools/

Upcoming Webinar: PFM Protocol Update

HHSC will host a webinar to update stakeholders on the PFM Protocol.

For more information, click http://www.texasrhp6.com/489/#more-489

RHP 6 Community Needs Assessment

The first draft of the RHP 6 Community Needs Assessment is now available. University Health System will continue to revise this document based on guidance from HHSC. Performing Providers and other stakeholders are encouraged to review this assessment and send comments to carol.huber@uhs-sa.com.

Notice to Performing Providers:

- Please continue to submit evidence of stakeholder meetings using the secure portal. For assistance, please contact Carol Huber at carol.huber@uhs-sa.com.
- Identify your current initiatives funded by U.S. Department of Health & Human Services (HHS). Please submit these with your DSIP proposals, or in advance to carol.huber@uhs-sa.com.
- Use the updated RHP Planning Protocol documents to update your proposed Category 1 and Category 2 projects.
- For each proposed Category 1 and 2 projects, Performing Provider must have a related Category 3 outcome. HHSC is still developing Category 3.
- Be prepared to describe how each of your proposed projects represent a new initiative or significantly enhances an existing initiative, including which initiatives may have related activities that are funded by HHS.
- Review the draft RHP6 Community Needs Assessment and provide feedback to carol.huber@uhs-sa.com.
RHP 6 Methodology for Project Prioritization, Selection, and Valuation

University Health System has developed a methodology for prioritizing, selecting, and valuing proposed DSRIP projects. (Click to view RHP 6 Methodology) Custom valuation templates will be emailed directly to Performing Providers. Performing Providers who intend to participate in the DSRIP program must complete and return the valuation tool by September 14, 2012.

Revised RHP 6 DSRIP Project Template
We are anticipating HHSC will provide a tool for Performing Providers to document proposed milestones, metrics, and estimated IGT for the DSRIP projects. To assist Providers in drafting the narrative required for each project, University Health System has developed a new project template. Due dates for these completed documents will be announced once HHSC releases the final CMS-approved RHP Planning Template.

New HHSC Webinars

HHSC is hosting two webinars on Friday, September 7.

- RHP Planning Protocol Webinar from 10 a.m. – 11:30 a.m.
- PFM Protocol Webinar from 1:30 pm – 3 p.m.

For more information on these webinars please visit the Texas RHP 6 Website.

Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/
September 12, 2012

DSRIP Project Valuations
As a reminder, Performing Providers must submit DSRIP Project Valuation spreadsheets by Friday, September 14, 2012. Click here for more information.

Request for Information
University Health System has been asked to provide HHSC with a list of potential Performing Providers interested in participating in DSRIP that have identified a source of non-federal match AND are one of the following:

- Hospitals that did not receive a Pass 1 Allocation
- Local health departments
- Community Mental Health Centers
- Physician Practices affiliated with an academic health science center
- Physician Practices not affiliated with an academic health science center

If your organization meets these criteria AND you did not receive a valuation template sent out on September 6, please email the following information to RHP6waiver@uhs-aa.com by September 14, 2012:

- Type of Performing Provider (Hospital, Local Health Department, Physician Practice)
- Performing Provider Name
- County
- TIP
- TIN (if available)

HHSC Webinars
HHSC held two webinars on Friday, September 7. During these presentations, HHSC announced that new/revised waiver documents and tools will be released by September 21. Trainings on these tools, including the RHP Plan Template, Electronic Workbook, and RHP Planning Protocol, will be held the week of September 17. The presentations are available here.
HHSC held an Anchor Call on Friday, September 14. Please note:

- View the complete online summary of the Anchor Call.

- Hospitals participating in the waiver will need to indicate “Ownership Type” to align with the UC application. Private entities contracted by hospital districts may need to submit affiliation agreements and certifications with the RHP plan. For more information, please email RHP6Waiver@UHS-SA.com.

- HHSC is seeking final CMS approval of the RHP Planning Protocol by September 21. Updated DRAFTs of the following documents are now available online:
  - Category 1
  - Category 2
  - Category 1 and 2 Project Options and Components
  - Category 3

- HHSC anticipates the Pass 1 electronic workbook and RHP Plan template to be available by September 21. The revised DRAFT RHP Plan template is available online.

- HHSC has tentatively scheduled upcoming webinars for September 25 and 26.

- HHSC has proposed a new timeline for development, review, and submission of the RHP Plans. The timeline targets submission of Pass 1 by October 31 and Pass 2 by November 30.

Performing Providers are encouraged to review the Anchor Call Notes and updated DRAFT documents, continue developing project proposals, and be prepared for quick turnaround deadlines once the final protocols and workbooks are released.

Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/
RHP Planning Protocol Update

HHSC expects federal approval of the complete Regional Healthcare Partnership (RHP) Planning Protocol (DSRIP menu) for the Medicaid 1115 Transformation Waiver on Monday, September 24, 2012. The protocol provides the menu of project areas approved by HHSC and the Centers for Medicare & Medicaid Services (CMS), and options that contribute to delivery transformation and quality improvement. Only projects from this menu and performed as outlined in an HHSC and a CMS-approved RHP Plan with corresponding measures, milestones and performance targets are eligible for payments from the DSRIP pool.

The Program Funding and Mechanics (PFM) Protocol and the RHP Planning Protocol (DSRIP menu) serve as the basis for RHP Plan development. The PFM Protocol was approved on August 31, 2012.

Final RHP Plan Template

The FINAL RHP Plan Template and a draft Companion document with additional instructions are now available. The electronic workbooks for Pass 1 Performing Providers, as specified in the PFM, are also posted. The Companion document includes a target timeline for RHP Plan submission for review and approval by HHSC and CMS. A final Checklist will follow this week.

HHSC is Hosting Two Webinars for RHP Plan Development and Submission

**RHP Planning Protocol Webinar**

Tuesday, September 25, 2012 from 9:00 a.m. – 10:30 a.m.:
1) Go to [www.webex.com](http://www.webex.com)
2) Click on Attend Meeting
3) Enter Meeting Number: 804 935 154 (no password necessary)
4) Call 1-800-396-3172 (no password necessary)

**RHP Plan Template Webinar**

Wednesday, September 26, 2012 from 10:30 a.m. – 12:00 p.m.:
1) Go to [www.webex.com](http://www.webex.com)
2) Click on Attend Meeting
3) Enter Meeting Number: 804 128 626 (no password necessary)
4) Call 1-800-396-3172 (no password necessary)
October 25, 2012 (resent November 1, 2012)

Dear Regional Healthcare Partnership 6 Stakeholders:

The University Health System will host a public meeting on the Regional Healthcare Partnership (RHP) 6 Plan, which includes the region’s first round of proposed projects under the state’s Medicaid 1115 Waiver. The meeting will take place:

Wednesday, November 7
10 a.m. to 11:30 a.m.
La Quinta Inn & Suites San Antonio Medical Center
4431 Horizon Hill Blvd.
San Antonio, TX 78229

The first round of projects, or Pass 1, under the Delivery System Reform Incentive Payment (DSRIP) Pool will be presented, followed by an opportunity for public comments. Both verbal and written comments will be accepted at the meeting. Comments also can be submitted online on the Regional Healthcare Partnership Region 6 website.

The deadline for submission of Pass 1 projects to the Texas Health and Human Services Commission (HHSC) is Nov. 16. The final RHP Plan, including Pass 2 projects, must be submitted by Dec. 31.

RHP 6 is anchored by University Health System and includes Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson and Zavala counties.

The Texas HHSC was awarded the demonstration waiver under Section 1115 of the Social Security Act from the Centers for Medicare and Medicaid Services on Dec. 12, 2011. DSRIP Pool Payments are intended as incentives to hospitals and other Performing Providers to develop projects that broaden access to health care, improve the quality of care and enhance the health of residents.

Performing Providers are encouraged to send representation to this meeting, but are not required to do so. Other interested parties are encouraged to attend. Attendance at the meeting will be documented.

For questions about the meeting, and to RSVP, please contact Sylvia Garcia at 210-358-0674 or Sylvia.garcia2@uhs-sa.com.
Public Meeting to Discuss Healthcare Improvement Projects

(SAN ANTONIO, TX – November 1, 2012) Hospitals and other healthcare providers from throughout 20 South Texas counties are working together on a plan with more than 70 proposed projects aimed at improving the quality of medical care and the health of families in our area. And at a gathering in San Antonio next week, the public can learn about the plan and comment on those projects before they’re submitted to state and federal health officials for approval.

The meeting will be held from 10 a.m. to 11:30 a.m. Wednesday, November 7 at the La Quinta Inn & Suites San Antonio Medical Center, 4431 Horizon Hill Blvd.

The projects would be funded under one part of the state’s Medicaid waiver, approved by the federal government in December under Section 1115 of the Social Security Act. Under the terms of the waiver, federal funds will be available over the next four years to fund projects within the 20 counties that make up Regional Healthcare Partnership 6. Those include Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson and Zavala counties.

Four categories of projects are eligible for funding under the waiver: infrastructure development, program innovation and redesign, quality improvements and population-focused improvements.

University Health System, which is hosting the public meeting, serves as anchor for the region. The meeting will highlight the first round of projects proposed for funding under the waiver. A second round of projects is being finalized. The final plan is due to the Texas Department of Health and Human Services on December 31.

Comments are invited at the hearing and can also be submitted online at www.texasrhp6.com.
University Health System, other South Texas providers seeking project funding

San Antonio Business Journal by W. Scott Bailey, Reporter/Project Coordinator
Date: Thursday, November 1, 2012, 4:07pm CDT

Hospitals and other health care providers from 20 South Texas counties are collaborating on a plan to seek funding for 70 proposed projects they contend would improve the quality of medical care and the health of families in the region.

The projects would be funded under a portion of the state’s Medicaid waiver approved by the federal government nearly a year ago.

The stakeholders must have their finalized plan to the Texas Department of Health and Human Services by Dec. 31.

San Antonio’s University Health System anchors the Regional Healthcare Partnership, which includes the counties of Atascosa, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson and Zavala.
November 6, 2012

Dear Regional Healthcare Partnership 6 Stakeholders:

University Health System is pleased to release the first draft of the RHP 6 Plan. Visit the website to receive a copy of the RHP 6 Plan. Comments and proposed changes will be accepted using the Regional Healthcare Partnership 6 Plan Public Comment Form, which is also available on the RHP website. Completed comment forms are due Friday, November 9 at 12:00 PM and may be submitted online through the RHP website.

As a reminder, the public meeting will take place:

Wednesday, November 7
10 a.m. to 11:30 a.m.
La Quinta Inn & Suites San Antonio Medical Center
4431 Horizon Hill Blvd.
San Antonio, TX 78229

For questions about the meeting and to RSVP, please contact Sylvia Garcia at 210-355-0674 or Sylvia.garcia2@uhs-sa.com.

Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/

November 30, 2012

RHP 6 Stakeholders:

University Health System submitted Phase 1 of the RHP Plan for Region 6 on November 16, 2012. We are currently compiling Phase 2 projects to complete the plan, which is due to HHSC on December 31, 2012.

University Health System is planning to host a webinar on December 13 to share the latest draft of the full plan. Further details regarding the webinar will be forthcoming. You can expect to receive an email next week inviting you to the webinar. You will be required to register for the webinar to receive the login instructions. The full RHP Plan will be posted to the website prior to the webinar.

Thank you for your interest in our Regional Healthcare Partnership.

Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/
December 7, 2012

RHP 6: RHP Plan Update
Join us for a Webinar on December 13

REGISTER NOW
Space is limited.
Reserve your Webinar seat now at:
https://www2.gotomeeting.com/register/725951250
During this event, representatives from University Health System will provide an updated summary of the RHP Plan which is due to the Texas Health and Human Services as part of the Texas Health Care Transformation and Quality Improvement Program (CMS 1115 waiver).
Title: RHP 6: RHP Plan Update
Date: Thursday, December 13, 2012
Time: 11:00 AM - 12:00 PM CST
After registering you will receive a confirmation email containing information about joining the Webinar.

System Requirements
PC-based attendies
Required: Windows® 7, Vista, XP or 2003 Server
Mac®-based attendies
Required: Mac OS® X 10.5 or newer
Mobile attendees
Required: iPhone®, iPad®, Android™ phone or Android tablet

Please send questions and requests to unsubscribe to carol.huber@uhs-sa.com. If this email was forwarded to you, and you would like to be added to distribution, please register here: http://www.texasrhp6.com/comments-feedback/
## Addendum D: List of DSRIP Projects

Region 6 is submitting the following DSRIP projects:

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Brief Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>159156201.1.1 – PASS 1</td>
<td>Expand primary care capacity by adding new primary care sites and/or increasing provider hours at existing sites.</td>
</tr>
<tr>
<td>1.1.1 Establish more primary care clinics: Expand primary care capacity Baptist Health System TPI: 159156201</td>
<td></td>
</tr>
<tr>
<td>159156201.1.2 – PASS 1</td>
<td>Expand specialty care capacity by adding new specialty care sites and/or increasing provider hours at existing sites.</td>
</tr>
<tr>
<td>1.9.2 Improve access to specialty care: Expand specialty care capacity Baptist Health System TPI: 159156201</td>
<td></td>
</tr>
<tr>
<td>159156201.1.3 – PASS 1</td>
<td>Expand existing process improvement programs by training additional staff, improved technology, increase scope and number of projects and enhance PT methods and workforce culture understanding.</td>
</tr>
<tr>
<td>1.10.1 Enhance improvement capacity within people Baptist Health System TPI: 159156201</td>
<td></td>
</tr>
<tr>
<td>(TPI Pending).1.1 – PASS 1</td>
<td>Improve access to sub-specialty care by establishing practices and creating clinics and other sites of services for children with subspecialty healthcare needs.</td>
</tr>
<tr>
<td>1.9.2 Improve access to specialty care: Pediatric Subspecialty Expansion Children’s Hospital of San Antonio TPI: 020844903</td>
<td></td>
</tr>
<tr>
<td>(TPI Pending).1.2 – PASS 1</td>
<td>Develop a geographically dispersed network of pediatric primary care clinics throughout Bexar County to enhance access points, increase available appointment times, and promote patient awareness.</td>
</tr>
<tr>
<td>1.1.2 Establish more primary care clinics: Primary Care Expansion Program Children’s Hospital of San Antonio TPI: 020844903</td>
<td></td>
</tr>
<tr>
<td>020844901.1.1 – PASS 1</td>
<td>Expand primary care capacity to an underserved area of Bexar County through the expansion of clinic space and the addition of four primary care providers.</td>
</tr>
<tr>
<td>1.1.2 - Expand existing primary care capacity CHRISTUS Santa Rosa Health System TPI: 020844901</td>
<td></td>
</tr>
<tr>
<td>112742503.1.1 – PASS 1</td>
<td>Provide regional psychiatric services to children ages 3-17 in a setting where a continuum of care is available, to effectively divert patients from local ER settings into the appropriate care level.</td>
</tr>
<tr>
<td>1.9.2 Improve access to specialty care Clarity Child Guidance Center TPI: 112742503</td>
<td></td>
</tr>
<tr>
<td>135151206.1.1 – PASS 1</td>
<td>Establish hospital owned and operated</td>
</tr>
<tr>
<td>Number</td>
<td>Status</td>
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<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>1.9.1 Expand high impact specialty care capacity in most impacted specialties</td>
<td>PASS 2</td>
</tr>
<tr>
<td>112690603.1.1 – PASS 1</td>
<td>1.9.1 - Expand high impact specialty care capacity in most impacted medical specialties: Improving Rural Access to Specialty Care</td>
</tr>
<tr>
<td>112690603.1.2 – PASS 2</td>
<td>1.6.2 – Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.</td>
</tr>
<tr>
<td>112688002.1.1 – PASS 1</td>
<td>1.1.2 Expand Primary Care Capacity</td>
</tr>
<tr>
<td>112688002.1.2 – PASS 2</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
</tr>
<tr>
<td>138411709.1.1 – PASS 1</td>
<td>1.1.2 Expand Existing Primary Care Capacity - GRMC</td>
</tr>
<tr>
<td>133260309.1.1 – PASS 1</td>
<td>1.1.2 Expand existing primary care capacity: a) expand primary care clinic space; b) expand primary care clinic</td>
</tr>
<tr>
<td>TPI</td>
<td>PASS</td>
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<tr>
<td>133260309.1.2</td>
<td>PASS 2</td>
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<tr>
<td>094154402.1.1</td>
<td>PASS 1</td>
</tr>
<tr>
<td>094154402.1.2</td>
<td>PASS 1</td>
</tr>
<tr>
<td>127294003.1.1</td>
<td>PASS 2</td>
</tr>
<tr>
<td>136491104.1.1</td>
<td>PASS 1</td>
</tr>
<tr>
<td>136141205.1.1</td>
<td>PASS 1</td>
</tr>
<tr>
<td>136141205.1.2</td>
<td>PASS 1</td>
</tr>
<tr>
<td>136141205.1.3</td>
<td>PASS 1</td>
</tr>
</tbody>
</table>
| University Hospital  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI: 136141205</td>
<td>Medicaid and uninsured patient population diagnosed with asthma.</td>
</tr>
</tbody>
</table>
| **136141205.1.4** – PASS 1  
1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: University Hospital Telemedicine Program  
University Hospital  
TPI: 136141205 | Employ telemedicine services to the Medicaid and uninsured pediatric/young adult asthma patient populations in the ambulatory setting. |
| **136141205.1.5** – PASS 1  
1.9.2 Expand access to specialty care (behavioral health)  
University Hospital  
TPI: 136141205 | Increase access to specialty care by expanding its provider base and having patients receive behavioral health services through its integrated patient-centered medical home. |
| **136141205.1.6** – PASS 1  
1.1.3 Expand school-based/mobile health clinics  
University Hospital  
TPI: 136141205 | Expand a mobile health clinic within major urban school districts. |
| **136141205.1.7** – PASS 2  
1.4.1 Expand Access to Written and Oral Interpretation Services  
University Hospital  
TPI: 136141205 | Strengthen access to culturally competent patient-centered care through strategies that promote timely oral interpretation/translation services, improve the fluid exchange of health information between patients and healthcare professionals and promote opportunities for patient to adhere to prescribed clinical care and treatment regimens. |
| **136141205.1.8** – PASS 3  
1.1.2 Expand existing primary care capacity: Patient-centered pediatric care  
University Hospital  
TPI: 136141205 | Increase pediatric primary care (including pediatric urgent care) clinic visit volume and provide evidence of improved access for patients seeking services. Accomplish this intervention through hiring more pediatricians and mid-level providers to enhance access for pediatric patients. |
| **136141205.1.9** – PASS 3  
1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Psychiatric Emergency Services (PES)  
University Hospital  
TPI: 136141205 | Development and expand a psychiatric emergency service with capacity to accommodate voluntary and involuntary patients with mental illness and in acute crisis. It offers an alternative to medical emergency rooms for those patients not requiring emergent/urgent evaluation and stabilization of physical medical |
<table>
<thead>
<tr>
<th>TPI</th>
<th>Status</th>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>136141205.1.10</td>
<td>PASS 3</td>
<td>1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Intervention Unit (CIU) University Hospital</td>
<td>Create a crisis intervention unit that can provide care in a safe environment for those patients who do not require acute care admissions.</td>
</tr>
<tr>
<td>136141205.1.11</td>
<td>PASS 3</td>
<td>1.8.6 Increase and expand oral health services University Hospital</td>
<td>Establish timely, accessible, integrated, and patient-centered preventive and primary oral health care services for economically vulnerable populations residing in Bexar County, Texas through a partnership between University Health System (UHS) and partner Federally Qualified Health Centers (FQHCs).</td>
</tr>
<tr>
<td>121782003.1.1</td>
<td>PASS 1</td>
<td>1.2.2 Increase the number of primary care providers and other clinicians/staff: Improving Rural Access to Primary Care Uvalde Memorial Hospital</td>
<td>Improve access to primary care within the rural service region through expanding capacity and a community health worker training program.</td>
</tr>
<tr>
<td>119877204.1.1</td>
<td>PASS 1</td>
<td>1.1.1 - Expand primary care capacity – Val Verde County and Del Rio, Texas Val Verde Regional Medical Center</td>
<td>Establish additional primary care providers to a medically underserved area along the Rio Grande border.</td>
</tr>
<tr>
<td>119877204.1.2</td>
<td>PASS 1</td>
<td>1.9.2 - Expand specialty care capacity for Val Verde County and Del Rio, TX Val Verde Regional Medical Center</td>
<td>Establish additional specialty care providers to a medically underserved area along the Rio Grande border.</td>
</tr>
<tr>
<td>119877024.1.3</td>
<td>PASS 2</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region – Val Verde County and Del Rio, Texas Val Verde Regional Medical Center</td>
<td>Introduce a robotic telemedicine program for access to specialty care in its rural community in the emergency room and inpatient bedded units.</td>
</tr>
<tr>
<td>92414401.1.1</td>
<td>PASS 2</td>
<td>1.2.2 Increase the number of primary care providers (nurse practitioners and physician assistants) and other clinicians/staff (allied health professionals) Community Medicine Associates</td>
<td>Increase training of mid-level providers including Nurse Practitioners and Physician assistants in the primary care setting.</td>
</tr>
<tr>
<td>085144601.1.1</td>
<td>PASS 1</td>
<td></td>
<td>Customize, implement, and evaluate</td>
</tr>
<tr>
<td>1.10.1 Enhance Improvement Capacity within people (Improving Inter-professional Team-Based Care for Patient Safety) UTHSCSA TPI: 085144601</td>
<td>an innovative evidence-based inter-professional team-based care model to achieve high team performance for patient safety in all healthcare practice settings of the Health Science Center.</td>
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<tr>
<td>085144601.1.2 – PASS 1 1.3.1 Implement/enhance and use chronic disease management registry functionalitites (Longitudinal Diabetes and Other Chronic Disease Registries to Improve Patient Outcomes) UTHSCSA TPI: 085144601</td>
<td>Create a quality improvement (QI) data mart for the outpatient management by UT Medicine Clinics, assist with building a parallel data mining resource for all University Health System clinics, and develop a Health Information Exchange (HIE) to ensure seamless exchange of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>085144601.1.3 – PASS 1 1.2.3 Increase the number of residency/training program for faculty/staff to support an expanded, more updated program: Residency Expansion for Family Medicine Residency UTHSCSA TPI: 085144601</td>
<td>Increase the number of primary care physicians in South Texas by increasing the number of Family Medicine residents in training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>085144601.1.4 – PASS 1 1.9.2 Improve access to specialty care: Implement EpicCareLink Referral Portal UTHSCSA TPI: 085144601</td>
<td>Make the specialty care services of UT Medicine more accessible to non-UT Medicine physicians throughout the South Texas area through the implementation of a web based, HIPAA compliant, referral portal integrated with UT Medicine’s EpicCare electronic health record (EHR) system.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>085144601.1.5 – PASS 1 1.3.2 “Other” project option: Populate a Chronic Disease Management Registry Using a Health Information Exchange System which Combines Ambulatory and Hospital Data UTHSCSA TPI: 085144601</td>
<td>This project will address the lack of connectivity between UT Medicine, University Health System and the community Health Information Exchange (HIE) Healthcare Access San Antonio (HASA).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>085144601.1.6 – PASS 1 1.14.2 Other project option: Expand specialty care capacity through the Sustained Treatment as an Outpatient Priority (STOP) Program UTHSCSA TPI: 085144601</td>
<td>Establish a clinical training program for treatment of Substance Use Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>085144601.1.7 – PASS 1 1.9.2 Improve Access to Specialty Care: Outpatient</td>
<td>Increase accessibility to outpatient neurology services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Reference</td>
<td>Status</td>
<td>Description</td>
<td></td>
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<tr>
<td>085144601.1.8</td>
<td>PASS 1</td>
<td>Improve Access to Specialty Care: Neuropsychological Services</td>
<td></td>
</tr>
<tr>
<td>085144601.1.9</td>
<td>PASS 1</td>
<td>Nurse-Managed Clinics: Improving Access, Expanding Clinical Sites, Promoting Interprofessional Education and Evidence-based Practice, Optimizing EHR Use and Financial Sustainability</td>
<td></td>
</tr>
<tr>
<td>085144601.1.11</td>
<td>PASS 1</td>
<td>Improve care for chronic disease and prevention and enhance behavioral health integration and availability by establishing two new primary clinics.</td>
<td></td>
</tr>
<tr>
<td>085144601.1.12</td>
<td>PASS 1</td>
<td>Establish an emergency dental clinic for treating patients presenting with urgent dental conditions including oral infections, abscesses, pain and fractured dental restorations.</td>
<td></td>
</tr>
<tr>
<td>085144601.1.13</td>
<td>PASS 1</td>
<td>Implement and train the dental school faculty, staff, dental/dental hygiene students and residents in the use of the certified electronic record.</td>
<td></td>
</tr>
</tbody>
</table>
| 085144601.1.15    | PASS 2 | Establish an innovative pilot South Texas (Bexar County) Hearing Health Care Delivery Model that incorporates existing and new resources including: Teleaudiology; a new level of support personnel (Teleaudiology Clinical Technicians (TCTs); “Drop-In Hearing Clinics”; community clinic collaborations; and existing partner audiologists, otolaryngologists and Primary Care Providers (MDs/NPs/PAs) and targets primarily members of the adult hard of hearing population; the majority of whom are
<table>
<thead>
<tr>
<th>TPI: 085144601</th>
<th>PASS 2</th>
<th>RHP Plan March 8, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>085144601.1.16</strong></td>
<td><a href="#">PASS 2</a></td>
<td>not receiving diagnostic/rehabilitative help for their hearing loss.</td>
</tr>
<tr>
<td><strong>085144601.1.17</strong></td>
<td><a href="#">PASS 2</a></td>
<td>Provide ideal cancer healthcare to underserved areas.</td>
</tr>
<tr>
<td><strong>085144601.1.18</strong></td>
<td><a href="#">PASS 2</a></td>
<td>Train new oncologists to enhance delivery of cancer care in underserved areas of South Texas.</td>
</tr>
<tr>
<td><strong>085144601.1.20</strong></td>
<td><a href="#">PASS 2</a></td>
<td>Implement CG CAHPS to measure patient satisfaction.</td>
</tr>
<tr>
<td><strong>085144601.1.23</strong></td>
<td><a href="#">PASS 2</a></td>
<td>Develop a mechanism to deliver epilepsy care to underserved areas in South and West Texas. The main focus of the outreach program will be to provide expanded outpatient care to people with epilepsy, both insured and indigent, who are predominantly Latinos.</td>
</tr>
<tr>
<td><strong>1268443-05.1.1</strong></td>
<td><a href="#">PASS 1</a></td>
<td>Develop a specialized therapeutic foster care setting (also called ‘treatment foster care’) that can be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility.</td>
</tr>
<tr>
<td><strong>1268443-05.1.2</strong></td>
<td><a href="#">PASS 1</a></td>
<td>Enhance service availability by establishment of a new community based setting where behavioral health services may be delivered in this underserved area.</td>
</tr>
<tr>
<td>TPI: 126844305</td>
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</tr>
</tbody>
</table>
| **121990904.1.1** – PASS 1  
1.13.1 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization  
Camino Real Community Services  
TPI: 121990904 |
| ![Description](image) |
| **121990904.1.2** – PASS 2  
1.12.3 Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care: mobile clinics  
Camino Real Community Services  
TPI: 121990904 |
| ![Description](image) |
| **137251808.1.1** – PASS 1  
1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Bexar CARES for Children: Crisis and Respite Center  
Center for Health Care Services  
TPI: 137251808 |
| ![Description](image) |
| **137251808.1.2** – PASS 1  
1.12.1 Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based setting in areas of the State where access to care is likely to be limited: Expanded OP Capacity  
Center for Health Care Services  
TPI: 137251808 |
| ![Description](image) |
| **137251808.1.3** – PASS 1  
1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Crisis Transitional Residential Services  
Center for Health Care Services  
TPI: 137251808 |
| ![Description](image) |
| **137251808.1.4** – PASS 1  
1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Children’s Mental Health Center for Health Care Services  
TPI: 137251808 |
| ![Description](image) |
| **137251808.1.5** – PASS 2  
1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Dual Diagnosis Clinic  
Center for Health Care Services |
<p>| <img src="image" alt="Description" /> |</p>
<table>
<thead>
<tr>
<th>TPI: 137251808</th>
<th>services to adults with a similarly co-occurring intellectual developmental disability (IDD) and mental health diagnosis.</th>
</tr>
</thead>
</table>
| **091308902.1.1** – PASS 1 | 1.8.9 – The implementation or expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise underserved children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.  
San Antonio Metropolitan Health District  
TPI: 082426001 | Expand community-based prevention programs that provide access to early diagnosis, fluoride varnish and dental sealants to serve additional children with unmet dental needs. |
| **159156201.2.1** – PASS 1 | 2.8.1 Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency  
Baptist Health System  
TPI: 159156201 | Using process improvement tools and trained workforce and apply to identify clinical care areas and processes to confirm to current best practices and reduce variation in treatment plans and health outcomes. |
| **020844901.2.1** – PASS 1 | 2.1.2 - Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients: Patient Centered Medical Home  
CHRISTUS Santa Rosa Health System  
TPI: 020844901 | Improve quality access to primary care for the Medicare and Medicaid population in the community by contributing to the expansion of medical homes. |
| **020844901.2.2** – PASS 1 | 2.12.1 - Develop, Implement, and evaluate standardized clinical protocols and evidenced-based care delivery model to improve care transitions: Care Transitions – Nurse Intervention Program  
CHRISTUS Santa Rosa Health System  
TPI: 020844901 | Create smooth transitions of care from the inpatient to outpatient setting, so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions. |
| **138411709.2.1** – PASS 1 | 2.12.2- Implement/Expand Care Transitions Program  
Guadalupe Regional Medical Center  
TPI: 138411709 | The project would implement improvements in transitioning patients and coordination of care from inpatient to outpatients, post-acute care, and home care settings. |
| **138411709.2.2** – PASS 2 | 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care  
Guadalupe Regional Medical Center  
TPI: 138411709 | Establish a patient navigation system to assist high utilizers of the ED to receive coordinated, timely and appropriate healthcare services. |
<table>
<thead>
<tr>
<th>TPI</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>136430906.2.1</td>
<td>Expand a wellness education and screening program to the uninsured employed residents living in Hill Country Memorial Hospital’s service area.</td>
</tr>
<tr>
<td>094154402.2.1</td>
<td>Redesign to improve patient experience- measure patient experience</td>
</tr>
<tr>
<td>094154402.2.2</td>
<td>Process improvement methodology to improve quality and efficiency- Performance improvement (sepsis)</td>
</tr>
<tr>
<td>112676501.2.1</td>
<td>Two new physicians to the market will base their Provider Based Clinic around the Patient Centered Medical Home Model (PCMH).</td>
</tr>
<tr>
<td>112676501.2.2</td>
<td>Similar to the process improvement practices implemented by the NICHE program, Nix will identify evidence based practices that may help improve the safety, quality and efficiency of the geriatric patients during their hospitalization, and work to incorporate these practices into the care these patients receive during their stay and post-discharge</td>
</tr>
<tr>
<td>112676501.2.3</td>
<td>Implement a Patient Navigator Program to help patients and their families navigate the fragmented maze of the healthcare system, including primary care physician offices, specialists, preventive screenings, diagnostic testing, inpatient admissions, payment systems, and community resources.</td>
</tr>
<tr>
<td>127294003.2.1</td>
<td>Implement a new discharge and care transition process.</td>
</tr>
<tr>
<td>TPI Code</td>
<td>PASS Level</td>
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<tr>
<td>136491104.2.1</td>
<td>PASS 1</td>
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<tr>
<td>133257904.2.1</td>
<td>PASS 1</td>
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<tr>
<td>136141205.2.1</td>
<td>PASS 1</td>
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<tr>
<td>136141205.2.2</td>
<td>PASS 1</td>
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<tr>
<td>136141205.2.3</td>
<td>PASS 1</td>
</tr>
<tr>
<td>136141205.2.4</td>
<td>PASS 1</td>
</tr>
</tbody>
</table>
| 136141205.2.5 | PASS 1 | Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Lifelong Intensive Family Emotional (L.I.F.E.) Care/Palliative Medicine Service. Provide access to comprehensive supportive care services for patients in Bexar County who are at risk for serious illness and to improve quality of life for patients and families facing
<table>
<thead>
<tr>
<th>University Hospital</th>
<th>Implement an innovative community-based intervention model to increase access to clinical preventive services throughout Bexar County, Texas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI: 136141205.2.7</td>
<td>Implement an innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammograms, immunizations): University Health System Preventive Screening Program University Hospital TPI: 136141205</td>
</tr>
<tr>
<td>2.7.1 - PASS 2</td>
<td>Dedicates one specially trained, culturally competent pharmacist to a selected Health System ambulatory “hub” clinic to implement chronic disease medication management among the patients assigned to that clinic.</td>
</tr>
<tr>
<td>University Hospital</td>
<td>Implement a care transitions program for patients identified as having congestive heart failure as a primary or secondary diagnosis. Within the project the target population and existing pre and post acute services will be identified for more comprehensive engagement and protocols will be established to prevent hospitalization and/or readmissions.</td>
</tr>
<tr>
<td>TPI: 136141205.2.9</td>
<td>University Hospital TPI: 136141205</td>
</tr>
<tr>
<td>2.12.2 PASS 3</td>
<td>This project takes a two prong approach using the evidence-based Chronic Care Model at helping patients manage their diabetes through providing training of their primary care providers to stratify the risk of their condition and recommending appropriate treatment, and allowing the patient to receive all necessary care through their usual place of healthcare.</td>
</tr>
<tr>
<td>University Hospital</td>
<td>Implement a palliative care program to address patients with end of life decisions and care needs Uvalde Memorial Hospital TPI: 121782003</td>
</tr>
<tr>
<td>2.10.1 PASS 2</td>
<td>Implement a palliative care program to address patients with end of life decisions and care needs.</td>
</tr>
<tr>
<td>Uvalde Memorial Hospital</td>
<td>Establish and align an</td>
</tr>
<tr>
<td>Title</td>
<td>Institution</td>
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<td>----------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| 2.2.2 Apply evidence-based care management model to patients identified as having high-risk care needs:  
   Implement Care Model for Clinic settings  
   Community Medicine Associates  
   TPI: 092414401 | interdisciplinary care coordination team including, but not limited to RN Case Managers, Social Workers, and Patient Educators to identify and support chronic and other health care needs and education. |  |
| 92414401.2.2 – PASS 2  
  2.1.1 - Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: Community Medicine Associates  
  TPI: 092414401 | Implement a Primary Care Home Model concept for CareLink members in Bexar County. |  |
| 085144601.2.1 – PASS 1  
  2.7.6 Implement other evidence based Disease Prevention Program in an innovative manner: TEACH (Targeting Environmental Aspects of Children’s Health)  
  UTHSCSA  
  TPI: 085144601 | Integrate Primary and Behavioral Health Care Services for children diagnosed with lead poisoning and asthma, and children with asthma. |  |
| 085144601.2.2 – PASS 1  
  2.15.1 Design, implement, and evaluate projects that provide integrated primary and Behavioral health care services: PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD)  
  UTHSCSA  
  TPI: 085144601 | PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD) is an integrated mental and physical health program for children with ADHD and related disorders. |  |
| 085144601.2.3 – PASS 1  
  Title:  2.13.2 Implement other evidence-based project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner  
  UTHSCSA  
  TPI: 085144601 | Expand the Transitional Care Clinic (TCC) to give patients rapid access to a prescriber upon hospital discharge or diversion from emergency departments (ED) and provide gap services and linkage to community services. The TCC also functions as a specialty training program in community psychiatry training residents and nurse practitioners |  |
| 085144601.2.4 – PASS 1  
  2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Community health worker program to address health and social needs in a vulnerable population  
  UTHSCSA  
  TPI: 085144601 | Implement a patient navigator program linked to a primary care safety net clinic to improve diabetes outcomes. |  |
| 085144601.2.5 – PASS 1  
  2.9.2 Implement other evidence based project to establish a patient care navigation program in an innovative manner:  
   Implement patient management consistent with the chronic care model (CCM) in a large safety net primary | Implement patient management consistent with the chronic care model (CCM) in a large safety net primary |  |
<table>
<thead>
<tr>
<th>Expanding chronic care management in a safety net clinic</th>
<th>care practice.</th>
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</thead>
<tbody>
<tr>
<td>UTHSCSA TPI: 085144601</td>
<td></td>
</tr>
<tr>
<td><strong>085144601.2.6 – PASS 2</strong></td>
<td>Develop and implement a novel program for managing individuals charged with alcohol-related driving offenses, which will provide the judicial system with a cost-effective alternative to jail and reduce rates of recidivism among offenders.</td>
</tr>
<tr>
<td>2.13.2 Implement other evidence based project to provide intervention for a targeted behavioral health population to prevent unnecessary use of services. (Transdermal Alcohol Monitoring Intervention to Reduce Drunk Driving, Lower Incarceration Costs, and Prevent Recidivism) UTHSCSA TPI: 085144601</td>
<td></td>
</tr>
<tr>
<td><strong>1268443-05.2.1 – PASS 1</strong></td>
<td>Work in collaboration with the Guadalupe Regional Medical Center to implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders.</td>
</tr>
<tr>
<td>2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutional health care: Patient Navigator for Persons with Chronic Mental Illnesses Bluebonnet Trails Community Services TPI: 126844305</td>
<td></td>
</tr>
<tr>
<td><strong>1268443-05.2.2 – PASS 2</strong></td>
<td>Implement a transitional housing facility that is provided consistent with SAMHSA recognized recovery principles.</td>
</tr>
<tr>
<td>2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Transitional housing with behavioral supports Bluebonnet Trails Community Services TPI: 126844305</td>
<td></td>
</tr>
<tr>
<td><strong>137251808.2.1 – PASS 1</strong></td>
<td>Implement a therapeutic justice model for persons who have been detained and/or incarcerated by Bexar County law enforcement and/or adjudicated by the court for outpatient commitment.</td>
</tr>
<tr>
<td>2.13.1 Design, implement and evaluate research supported and evidence-based interventions tailored towards individuals in the target population, i.e., persons who have been adjudicated in the court and criminal justice system implementing a therapeutic justice model in Bexar County.: Intensive Outpatient/Criminal Justice Center for Health Care Services TPI: 137251808</td>
<td></td>
</tr>
<tr>
<td><strong>137251808.2.2 – PASS 1</strong></td>
<td>Establish a comprehensive, integrated care management center offering primary and behavioral health care at Prospects Courtyard (PCY) within the Haven for Hope campus.</td>
</tr>
<tr>
<td>2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: PCY Integrated Clinic Center for Health Care Services TPI: 137251808</td>
<td></td>
</tr>
<tr>
<td><strong>137251808.2.3 – PASS 1</strong></td>
<td>Embed and integrate primary care services at the Restoration Center, a comprehensive substance abuse treatment facility.</td>
</tr>
<tr>
<td>2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: Integrated Primary Care for SA and HIV Population Center for Health Care Services TPI: 137251808</td>
<td></td>
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<tr>
<td>TPI: 137251808.2.4</td>
<td>PASS 2</td>
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<tr>
<td>2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Coordinated Community Integrated Care Response for Super-Utilizing Consumers-Expand and Enhance Pilot Project Center for Health Care Services</td>
<td></td>
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<tr>
<td>Expand a current CHCS pilot that is developing a community collaborative response to identifying and providing effective interventions to high utilizers.</td>
<td></td>
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<table>
<thead>
<tr>
<th>TPI: 137251808.2.5</th>
<th>PASS 2</th>
</tr>
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<tbody>
<tr>
<td>2.13.2 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services: In House Women's Wellness Program (IHWWP)/Day Treatment Center for Health Care Services</td>
<td></td>
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<tr>
<td>Establish a 24-bed comprehensive, safe, structured dormitory for females at the Haven for Hope campus.</td>
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<thead>
<tr>
<th>TPI: 133340307.2.1</th>
<th>PASS 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.3.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mobile Crisis Outreach Teams</td>
<td></td>
</tr>
<tr>
<td>Implement two Mobile Crisis Outreach Teams. Mobile Crisis Outreach Team (MCOT) activities include Crisis Assessment, Treatment Placement, and Preventive Crisis Support Services.</td>
<td></td>
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<table>
<thead>
<tr>
<th>TPI: 133340307.2.2</th>
<th>PASS 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.16.1 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hill Country Virtual Psychiatric and Clinical Guidance</td>
<td></td>
</tr>
<tr>
<td>Provide PCPs and hospitals within Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde counties with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions through Psychiatric Consultation.</td>
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<tr>
<th>TPI: 133340307.2.3</th>
<th>PASS 1</th>
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<tbody>
<tr>
<td>2.1.3.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder</td>
<td></td>
</tr>
<tr>
<td>Add Co-occurring Psychiatric and Substance Use Disorder services throughout the eleven county area served by Hill Country in RHP6.</td>
<td></td>
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<thead>
<tr>
<th>TPI: 133340307.2.4</th>
<th>PASS 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care</td>
<td></td>
</tr>
<tr>
<td>Establish Trauma Informed Care throughout the eleven counties served by Hill Country in RHP6. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges</td>
<td></td>
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<tr>
<td>TPI</td>
<td>Status</td>
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<tr>
<td><strong>133340307.2.5</strong> – PASS 2</td>
<td>2.18.1 Design, implement, and evaluate whole health peer support for individuals with mental health and/or substance use disorders: Whole Health Peer Support</td>
</tr>
<tr>
<td>Hill Country Mental Health and Developmental Disabilities Center</td>
<td></td>
</tr>
<tr>
<td>TPI: 133340307</td>
<td></td>
</tr>
<tr>
<td><strong>133340307.2.6</strong> – PASS 2</td>
<td>2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Veteran Mental Health Services</td>
</tr>
<tr>
<td>Hill Country Mental Health and Developmental Disabilities Center</td>
<td></td>
</tr>
<tr>
<td>TPI: 133340307</td>
<td></td>
</tr>
<tr>
<td><strong>133340307.2.7</strong> – PASS 2</td>
<td>2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Mental Health Courts</td>
</tr>
<tr>
<td>Hill Country Mental Health and Developmental Disabilities Center</td>
<td></td>
</tr>
<tr>
<td>TPI: 133340307</td>
<td></td>
</tr>
<tr>
<td><strong>091308902.2.1</strong> – PASS 1</td>
<td>2.6.4 Implement other evidence-based health promotion programs in an innovative manner: Comprehensive Teen Pregnancy Prevention</td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td></td>
</tr>
<tr>
<td>TPI: 082426001</td>
<td></td>
</tr>
<tr>
<td><strong>091308902.2.2</strong> – PASS 1</td>
<td>2.6.4 “Other” project option: implement other evidence-based health promotion programs in an innovative manner: Neighborhood Based Physical Activity and Health Promotion Project</td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td></td>
</tr>
<tr>
<td>TPI: 082426001</td>
<td></td>
</tr>
<tr>
<td><strong>091308902.2.3</strong> – PASS 1</td>
<td>2.6.2 Establish self-management programs and wellness using evidence-based designs: Community Diabetes Project</td>
</tr>
<tr>
<td>San Antonio Metropolitan Health District</td>
<td></td>
</tr>
<tr>
<td>TPI: 082426001</td>
<td></td>
</tr>
</tbody>
</table>
2.7.6 Implement other evidence-based disease prevention programs in an innovative manner: HIV and Syphilis Reduction in Bexar County
San Antonio Metropolitan Health District
TPI: 082426001
Reduce the burden of sexually transmitted diseases and HIV and improve the health status of adolescents and adults in San Antonio, Texas by enhancing disease prevention and control strategies.

2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents – Breastfeeding Promotion for Childhood Obesity Prevention
San Antonio Metropolitan Health District
TPI: 082426001
Establish a “Baby Café” breastfeeding drop-in center to expand services and attract mothers of all ages and from all sectors of the community. This will be done by providing breastfeeding help and support, from both skilled health professionals, para-professionals, and other mothers, in a friendly, non-clinical, café style environment.

Region 6 considered but did not select the following DSRIP projects:

<table>
<thead>
<tr>
<th>Performing Provider</th>
<th>Project Option</th>
<th>Brief Description of Proposed Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist Health System 159156201</td>
<td>1.7.3 Use Telehealth to deliver specialty, psycho social, and community based nursing services</td>
<td>Establish a Nurse Advice line to provide information on health and wellness, provide a next day primary care visit if needed and prevent unnecessary ED visits and prevent avoidable admissions. Support at risk populations including pediatrics. CHF and diabetes while also promoting preventative services.</td>
</tr>
<tr>
<td>Baptist Health System 159156201</td>
<td>2.6.2 Establish self-management programs and wellness using evidence based designs</td>
<td>Develop an employee Wellness program for BHS employees on our medical plan and then expand to other large employers supporting our medical plan design to encourage preventative care, healthy behavior and promote primary care management of health. Employees will participate in biometric screening with a roadmap to improve health, provide health coaching and disease management with incentives for reduced medical premiums based on participation and results of controllable health indicators.</td>
</tr>
<tr>
<td>Baptist Health System 159156201</td>
<td>2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs</td>
<td>Implement a Palliative Care Program to address patients with end-of-life decisions and care needs</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
<td>Introduce, expand or Enhance Telemedicine/Telehealth: (Telemedicine) To enhance our level of psychiatric and clinical services to improve and increase access to mental health services and treatment.</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas</td>
<td>Enhance Service Availability, expand the number of community based settings where behavioral health services may be delivered in underserved areas: (Home Health Expansion) Establish a Community Based Home Care agency that will serve individuals of all ages who currently do not meet the “home bound criteria” rule for delivery of services under Medicare (conditions of participation), who currently over or inappropriately utilize the system emergency and urgent care facilities, and inpatient facilities in lieu of developing relationships with primary care physician services or are very ill when they present for services and require very expensive crisis treatment.</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting</td>
<td>Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: (Residential detoxification) Expand current capacity to provide residential detoxification with a transition to sober living in an effort to prevent unnecessary use of services in an urgent care setting.</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>1.12.1 Establish extended operating hours at select number of local mental health center clinics or other community-based settings in areas of the state where access to care is likely to be limited</td>
<td>Establish extended operating hours at a select number of Local Mental Health Center clinics or other community-based setting in areas of the State where access to care is likely to be limited: Expanded OP Capacity – Expansion of Previous project (unique identifier 137251808.1.2) to widen resources beyond previously determined.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>2.4.1 Implement processes to measure and improve patient experience</td>
<td>The primary goal of this project is to improve how the patient and family experience the care they receive and ultimately to improve the patient and family’s satisfaction with the care provided. The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve the practitioners in a clinic as well as the patients and their families or caregivers.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>2.6.1 Engage in population-based campaigns or programs to promote healthy</td>
<td>The goal of this program is to create a seamless continuum of care from prenatal diagnosis, ante partum care, labor and deliver, post partum care and neonatal</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>1.6.3 Other project option: Pediatric Transport Program</td>
<td>The goal of this project is to create a 24 hour transfer intake center that facilitates rapid transfer of critically ill children from small, lower acuity health centers to Children’s Hospital of San Antonio’s (CHofSA) tertiary level of pediatric care. Additionally, the transfer center would allow outpatients from rural communities across South Texas to have one number to call to schedule appointments with sub-specialty physicians.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs</td>
<td>This project involved the expansion of the Asthma program which targets low-income children. The primary objective is to serve children with asthma through group and/or individual bedside instruction, as well as outreach, service and support in the community.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>2.6.1 Engage in population-based campaigns or programs to promote healthy lifestyles using evidenced-based methodologies including social media and text messaging in an identified population</td>
<td>The goal of this program is to create a seamless continuum of care from prenatal diagnosis, ante partum care, labor and deliver, post partum care and neonatal care to meet the needs of high risk patients.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>1.6.3 Other project option: Pediatric Transport Program</td>
<td>The goal of this project is to create a 24 hour transfer intake center that facilitates rapid transfer of critically ill children from small, lower acuity health centers to Children’s Hospital of San Antonio’s (CHofSA) tertiary level of pediatric care. Additionally, the transfer center would allow outpatients from rural communities across South Texas to have one number to call to schedule appointments with sub-specialty physicians.</td>
</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs</td>
<td>This project involved the expansion of the Asthma program which targets low-income children. The primary objective is to serve children with asthma through group and/or individual bedside instruction, as well as outreach, service and support in the community.</td>
</tr>
<tr>
<td>Organization</td>
<td>Objective</td>
<td>Description</td>
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</tr>
<tr>
<td>Children's Hospital of San Antonio</td>
<td>high-risk health care needs, well as outreach, service and support in the community.</td>
<td>Happy Kids, Healthy Kids: The goal of this project is to empower children and their families to adopt healthier habits around food and physical activities. There are six key areas that are focused on: Weight loss, healthy eating habits, lower BMI, increased physical activity, better overall health, and an enhanced support system.</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health System</td>
<td>2.6.2 Establish self-management programs and wellness using evidence-based designs</td>
<td>The goal of this project was to establish/expand primary care training programs by implementing additional slots to the CHRISTUS Santa Rosa Family Residency Program.</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health System</td>
<td>1.2.4 Establish/expand primary care training programs, with emphasis in communities designated as health care provider shortage areas</td>
<td>This project proposed the implementation of a software solution called Vocera Care Transitions. It focused on the use of &quot;Good to Go&quot; designed specifically for patient discharge.</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health System</td>
<td>2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population</td>
<td>This project included the implementation of a telemedicine program to provide or expand specialist referral services for mental health patients.</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health System</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
<td>Race, Ethnicity and Language (REAL): would provide CHRISTUS Santa Rosa Health System with an effective tool to help identify and address disparities in care.</td>
</tr>
<tr>
<td>CHRISTUS Santa Rosa Health System</td>
<td>1.5.3 Implement system to stratify patient outcomes and quality measures</td>
<td>The goal of this project is to improve how the patient experiences the care and the patient's satisfaction with the care provided.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Clarity Child Guidance Center</th>
<th>1.12 Enhance serve availability of appropriate levels of behavioral health care</th>
<th>Open neighborhood based “rapid access clinics” to increase access to mental health care, while creating a new model of care that is designed to provide proactive, preventive outpatient care in a 4-8 visit model.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimmit County Memorial Hospital</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
<td>This project was designed to provide access to medical specialists as needed by patients and their physicians. This may have overcome access barriers related to the community’s rural location.</td>
</tr>
<tr>
<td>Dimmit County Memorial Hospital</td>
<td>1.6.1 Expand Urgent Care</td>
<td>This project was designed to increase primary care capacity through the establishment of an urgent care center. This would have decreased non-emergent patient volume in the ED.</td>
</tr>
<tr>
<td>Dimmit County Memorial Hospital</td>
<td>1.1.2 Expand existing primary care capacity</td>
<td>This project was designed to expand primary care capacity by increasing clinic space, hours and staffing. The aim of this project was to shift non-emergent patient volume from the ED to primary care.</td>
</tr>
<tr>
<td>Frio Regional Hospital</td>
<td>1.2 Expand Training of Primary Care Workforce</td>
<td>Analyze patient throughput in the clinic setting to find opportunities for improvement. Hire consultants to train clinic staff on staffing and scheduling to improve patient flow.</td>
</tr>
<tr>
<td>Frio Regional Hospital</td>
<td>1.6 Enhance Urgent Medical Advice</td>
<td>Analyze percentage of those presenting in the emergency department with urgent as opposed emergent conditions. Prepare plans to provide separate urgent care service on the hospital campus.</td>
</tr>
<tr>
<td>Hill Country Memorial Hospital</td>
<td>1.1.1 Establish more primary care clinics</td>
<td>Support the initial costs of a local FQHC to open a clinic for the uninsured in the community. Goal of seeing at least 6000 patient encounters in the 4 demonstration years.</td>
</tr>
<tr>
<td>Hill Country</td>
<td>2.3.1 Redesign primary care</td>
<td>Redesign primary care in order to achieve improvements</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>care in order to achieve improvements in efficiency, access, continuity of care, and patient experience. In efficiency, access, continuity of care, and patient experience - improvements to 501a primary care clinics and support to other local clinics seeking to pursue patient centered medical home qualities.</td>
<td></td>
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</tr>
<tr>
<td>Medina Regional Hospital</td>
<td>1.9 Expand Specialty Care Services As more specialists are needed in Medina County, we considered 1.9 (Expand Specialty Care Services). To provide timely access to care, decrease ED visits, and to improve patient satisfaction (not requiring a drive into San Antonio), specialists are needed in dermatology, pulmonary, podiatry, general surgery and pain management. We considered, as more specialists are needed, but were unsure if we could meet the metrics. Primary care was more important for Medina County.</td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital</td>
<td>Category 1- 1st DRAFT- removed by HHSC Enhance Coding and Documentation for Quality Data</td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital</td>
<td>1.3.1 Implement / enhance and use chronic disease management registry functionalities Implement and Utilize Oncology Treatment Management Registry Functionality</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth Establish telemedicine program to reach rural markets with specialists in under-served areas</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.12 Enhance service availability to appropriate levels of behavioral health care Expand behavioral health capacity</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.12 Enhance service availability to appropriate levels of behavioral health care Expand behavioral health continuum to include IOP and PHP programs</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.12 Enhance service availability to appropriate levels of behavioral health care Expand Psych Mobile Assessment Team to surrounding rural areas</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.6 Enhance Urgent Medical Advice Expand Geriatric Mobile Assessment Team to surrounding rural areas</td>
<td></td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.4 Redesign to Improve Patient Experience</td>
<td>Redesign patient experience through innovative direct-admit process</td>
</tr>
<tr>
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<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.1 Expand Primary Care Capacity</td>
<td>Expand PCP capacity by recruiting additional PCPs to market, or assisting existing PCPs through Provider-Based Clinics</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.7 Implement Evidence-based Disease Prevention Programs</td>
<td>Implement evidence-based strategies to increase screenings for sleep apnea</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.3 Redesign Primary Care</td>
<td>Implement the patient-centered-scheduling model in our primary care clinics</td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.9 Expand Specialty Care Capacity</td>
<td>Expand Specialty Care providers for orthopedics/spine</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.12 Implement/Expand Care Transitions Programs</td>
<td>Expand Care Transitions Program</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.7 Implement Evidence-based Disease Prevention Programs</td>
<td>Implement evidence-based strategies to increase screenings for morbid obesity and referrals to weight-loss programs/surgery</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.7 Implement Evidence-based Disease Prevention Programs</td>
<td>Implement evidence-based strategies to increase screenings for breast cancer (mammograms)</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.2 Expand Chronic Care Management Models</td>
<td>Formalize a diabetes prevention/treatment protocol for use in provider-based clinics</td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.10 Enhance Performance Improvement and Reporting Capacity</td>
<td>Implement processes and environmental changes to enhance coding and documentation</td>
</tr>
<tr>
<td>Nix Health</td>
<td>1.6 Enhance Urgent Medical Advice</td>
<td>Expand urgent-care services</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.5 Redesign for Cost Containment</td>
<td>Implement cost-accounting systems to measure intervention impacts</td>
</tr>
<tr>
<td>Nix Health</td>
<td>2.15 Integrate Primary and Behavioral Health Care Services</td>
<td>Integrate behavioral health providers into our PCP provider based clinics</td>
</tr>
<tr>
<td>Peterson</td>
<td>1.1.2 Expand existing</td>
<td>Open a primary care practice for unfunded/underfunded</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Regional Medical Center</th>
<th>primary care capacity targeted population. Providers would consist of mostly nurse practitioners that would have been overseen by one of our hospitalists as the medical director.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterson Regional Medical Center</td>
<td>2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic disease Implement a Chronic Disease Management program that would assist with patient education on disease process and self-management, assist case management department in arranging post hospital follow up and resources, assist healthcare providers in closing the gaps of care transition from inpatient to outpatient, as well as frequent follow-up checks with patient to ensure better patient and health care outcomes.</td>
</tr>
<tr>
<td>Peterson Regional Medical Center</td>
<td>2.10.1 Implement a palliative care program to address patients with end-of-life decisions and care needs Open a palliative care outpatient practice</td>
</tr>
<tr>
<td>Peterson Regional Medical Center</td>
<td>2.4.1 Implement processes to measure and improve patient experience To give mothers and newborns better post hospital access to and education for breastfeeding support. Certified breastfeeding instructor will provide opportunities for mothers to return for continued breastfeeding assistance.</td>
</tr>
<tr>
<td>Southwest General Hospital</td>
<td>1.9.2 Increase service availability (hours, clinic locations, etc.). Improve access to specialty care. Expand mobile clinics. Redesign Primary Care. Redesign to improve patient experience Through the development of a mobile primary care unit, the surrounding rural communities will have the opportunity to access a variety of health resources in a timely and cost effective manner. Expand the capacity of primary care through a mobile care unit 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.</td>
</tr>
<tr>
<td>Southwest General Hospital</td>
<td>1.9.2 Increase service availability (hours, clinic locations, etc.) Improve access to specialty care. Establish or expand initiatives to increase the availability of targeted specialty providers The development of a specialty care program dedicated to cardiac testing and interventions will provide the opportunity to access a vital health resource to identify potentially serious cardiovascular events in a timely and cost effective manner. The service is critical to support the patients requiring further assessment and intervention when identified as high risk by Primary Care Provider.</td>
</tr>
<tr>
<td>University Hospital</td>
<td>1.9.1 Expand high impact specialty care capacity in most impacted medical In order to develop the first civilian Emergency Medicine residency training program in South Central Texas, the UT Medicine Division of Emergency Medicine will partner with University Health System as</td>
</tr>
<tr>
<td>Institution</td>
<td>Specialty/Project Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>specialties well as several of the community’s health care facilities to ensure resident education will directly impact the community, the citizens of Bexar County and South Texas.</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>2.9. Establish a Patient Navigation Program</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>1.3.2 Implement other evidence based project to implement a chronic disease management registry</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>1.9.3 Implement other evidence based project to expand specialty care capacity in an innovative manner</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health and or/substance abuse disorders</td>
</tr>
<tr>
<td>University of Texas Health Science Center at San Antonio</td>
<td>1.9.3 Implement other evidence based project to expand specialty care capacity in an innovative manner</td>
</tr>
<tr>
<td>Uvalde Memorial Hospital</td>
<td>1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td>
</tr>
<tr>
<td>Uvalde Memorial Hospital</td>
<td>1.6.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency</td>
</tr>
<tr>
<td>Uvalde Memorial Hospital</td>
<td>1.9.1 Expand high impact specialty care capacity in most impacted medical specialties</td>
</tr>
</tbody>
</table>
Addendum E: Affiliation Agreements and Certifications

- Clarity Child Guidance Center – Affiliation Agreement
- Clarity Child Guidance Center – Certification of Hospital Participation
- Dimmit Regional Hospital – Certification of Hospital Participation
- Dimmit Regional Hospital District – Certification of Governmental Entity Participation
- Dimmit Regional Hospital – Affiliation Agreement
- Fredericksburg Hospital Authority – Certificate of Governmental Entity Participation
- Peterson Regional Medical Center – Affiliation Agreement with Fredericksburg Hospital Authority
- Peterson Regional Medical Center – Certification of Hospital Participation
- South Texas Regional Medical Center – Certification of Hospital Participation
- Southwest General Hospital – Affiliation Agreement
- Southwest General Hospital – Certification of Hospital Participation
- University Health System / CHRISTUS Health System / Children’s Hospital of San Antonio / Baptist Health System / Methodist Healthcare System – Affiliation Agreement
- Wilson County Hospital District – Certification of Governmental Entity Participation
The following documents are included in this addendum:

- Anchor Checklist (Submitted 12/21/12)
- RHP 6 Response to HHSC Initial Feedback on Pass 1 Projects (Submitted 12/21/12)
- RHP 6 Section I-VII Response to HHSC Feedback (Submitted 3/8/13)
- RHP 6 Changes impacting provider workbooks (Submitted 3/8/13)
- RHP 6 Response to Non-Approvable List (Submitted 3/8/13)