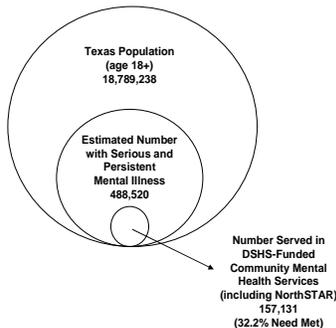


Project: Improve the infrastructure for delivery of behavioral health services.

The goals of projects under this heading are to improve the access to appropriate behavioral health interventions and specialists throughout Texas. This is an especially critical need in Texas for several reasons:

- State funding for behavioral health indigent care is limited. Texas ranks 50th in per capita funding for state mental health authority (DSHS) services and supports for people with serious and persistent mental illness and substance use disorders. Medically indigent individuals who are not eligible for Medicaid have no guarantee of access to needed services and may face extended waiting periods.
- Texas ranks highest among states in the number of uninsured individuals per capita. One in four Texans lack health insurance. People with behavioral health disorders are disproportionately affected. For example, 60 percent of seriously mentally ill adults served in the public mental health system are uninsured.¹
 - The supply of behavioral health care providers is inadequate in most of the State. In April of 2011, 195 (77%) of Texas' 254 counties held federal designations as whole county Health Provider Shortage Areas (HPSAs). This is an increase from the 183 counties designated in 2002.²



Projects / project elements under this heading are designed to increase the supply of behavioral health professionals practicing in the State, extend the capacity of behavioral health providers to offer expertise to other health care providers, such as primary care physicians and enhance the capacity of behavioral health and other providers to effectively serve patients with behavioral health conditions. Examples of such projects could include

training and residency programs for behavioral health providers, programs which expand access to certified peer support services, telehealth consultation programs in which behavioral health providers offer timely expertise to primary care providers and extended clinic hours / mobile clinics.

Project Options:

- Implement technology-assisted services (telemedicine, telehealth, and telemonitoring) to support, coordinate, or deliver behavioral health services.
- Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).
- Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care
- Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas (i.e., psychiatrists, psychologists, LMSWs, LPCs and LMFTs).
- Recruit, train and support consumers of mental health services to be providers of

¹ DSHS Decision Support, 2012

² "Highlights: The Supply of Mental Health Professionals in Texas -2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at: <http://www.dshs.state.tx.us/chs/hprc/publicat.shtm>

Project I.1.A : Implement technology-assisted services (telemedicine, telehealth, and telemonitoring) to support, coordinate, or deliver behavioral health services.

- **Project Goal**

Texas faces several access barriers that make the deployment of workable integrated health care models a challenge. Specifically, Texas is composed of 254 counties, the majority of which can be classified as either “rural” or “frontier”. The availability of health care providers is severely limited in many of these sparsely populated areas. While these shortages make access to physical healthcare difficult for those who reside in these rural areas, the impact on individuals with behavioral health needs is even more severe. For example, in 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor .

There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health. Furthermore, certain specialties (such as Child Psychiatrists) are virtually non-existent in the vast majority of the rural and frontier areas of the state.

Additionally, the size of the state makes travel from these underserved areas to larger urban settings difficult. For individuals who lack reliable transportation or have disabilities that restrict driving, the challenge of accessing health care may be virtually insurmountable.

Furthermore, there are many non-rural areas of the state where the availability of health care professionals is greatly limited. For example, in Bexar country, which has one of the largest urban populations in Texas, there are 123 areas within the county have been designated as HPSAs by HRSA. Similar shortages can be found in most Texas urban counties.

Modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services. The developments in internet-based communications that began with voice messaging have been extended to video in the form of widely available video compression technologies that allow for high quality, real time, face-to-face communications and consultations over relatively inexpensive telecommunications equipment. With this new technology, in any area of the state where high speed broadband internet access is available, access to many forms of health care can become a reality. To leverage the promise of this new technology, Texas would like to expand the use of telemedicine, telehealth, and telemonitoring to thereby increase access to, and coordination of, physical and behavioral healthcare.

Project Elements
1. Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state.
2. Assess the local availability of, and need, for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.
3. Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.
4. Procure and build the infrastructure needed to implement each of the three selected forms of service in underserved areas of the state.
5. Identify qualified providers that will connect via telemedicine, telehealth, or telemonitoring.
6. Identify modifiers needed to track encounters performed via a video device.
7. Develop and implement data collection and reporting standards for electronically delivered services

Comment [MD1]: Assume you mean provider-to-provider communication? If so, you should clarify.

Key Process Milestones		
<i>Regional Partnerships undertaking this project may select from among the following Milestones</i>		
Milestone	Metric(s)	Data Source(s)
1. Identify Texas counties having availability to high speed broadband communications lines.	<ul style="list-style-type: none"> Conduct an assessment of counties to identify areas of the state that have or lack capacity for high speed broadband connections capable of supporting telemedicine, telehealth, and telemonitoring 	<ul style="list-style-type: none"> Results of the assessment as tallied by state staff members.
2. a. Establish the number of providers in underserved areas that have or do not have telecommunications equipment that can be used to provide telemedicine, telehealth or telemonitoring services. b. Determining the number of providers that would make use of such equipment if it were made available.	<ul style="list-style-type: none"> A survey of providers to identify need for and willingness to use advanced telecommunications equipment in the delivery or telemedicine, telehealth or telemonitoring. 	<ul style="list-style-type: none"> Provider responses to the survey.

Comment [C2]: I think you need to add process and improvement metrics that relate to potential project elements 4-7. None of these really relate to actual implementation of telemedicine services.

Key Process Milestones*Regional Partnerships undertaking this project may select from among the following Milestones*

Milestone	Metric(s)	Data Source(s)
3. Evaluate effective and efficient models for the delivery of telehealth, telemedicine, and telemonitoring.	<ul style="list-style-type: none"> Examine existing technology and models as well as information from leading providers of telemedicine, telehealth and telemonitoring services. 	<ul style="list-style-type: none"> Information from literature and interviews of leading providers of these services.

Comment [C2]: I think you need to add process and improvement metrics that relate to potential project elements 4-7. None of these really relate to actual implementation of telemedicine services.

Project I.1.B: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).

Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. These populations often have multiple concomitant issues such as substance use; traumatic injuries; homelessness, cognitive challenges; lack of daily living skills and lack of natural supports. The State's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe mental diagnoses and functional limitations, but can serve only a fraction of the medically indigent population, does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex mental and physical needs. These complex populations become frequent users of local public health systems

The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to treatment; and to promote recovery in the community. This can be done by providing community based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient system; and the mental health system. Examples of interventions could include integrated medical and non-medical supports such as transition services to help individuals establish a stable living environment, peer support, specialized therapies, medical services, personal assistance, and short or long term residential options.

Residential options linked to a range of support services can effectively improve health outcomes for vulnerable individuals, such as the long-term homeless with severe mental illness. One such model in Colorado demonstrated a drastic 80 percent decrease in overnight hospital stays and a 76 percent decrease in nights in jail. Research indicates that among residents of permanent supportive housing:

- Rates of arrest and days incarcerated are reduced by 50%;
- Emergency room visits decrease by 57%;
- Emergency detoxification services decrease by 85%; and
- Nursing home costs decrease by 50%.³

³ Lewis, D., Corporation for Supportive Housing, *Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010*. Retrieved from <http://www.caction.org/homeless/documents/AustinModelPresentation.pdf>

Potential Project Elements
<p>A. Assess size, characteristics and needs of target population and review literature / experience with similar populations</p> <p>B. Design interventions</p> <p>C. Implement interventions</p> <p>D. Assess the impact of interventions</p>

Comment [C3]: Need much more specificity in all of these elements, especially B-D. What sorts of interventions are you envisioning?

Key Process Measures
Regional Partnerships undertaking this project may select from among the following measures, with their associated metrics and data sources.

Measure	Metric(s)	Data Source(s)
Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources.	Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization	<ul style="list-style-type: none"> Inpatient, discharge and ED records State psychiatric facility records survey of stakeholders (inpatient providers, mental health providers, social services and forensics) literature review
Design community-based specialized interventions for target populations.	Project plans which are based on evidence / experience and which address the project goals	Project documentation
Enroll and serve individuals with targeted complex needs	Number of targeted individuals enrolled / served in the project.	Project documentation
Determine the impact of the project.	Evaluation plan including metrics, operational and evaluation protocols	Project documentation

Comment [C4]: Again, much more detail needed – these metrics are way too broad.

Comment [C5]: Need to identify what you mean by complex needs – diagnoses, housing status, etc.?

Comment [C6]: I don't know if this is really a metric. Seems like one of the project elements should be an evaluation plan, and the metrics embedded within could be placed here. I think you need to articulate the process and outcome metrics you would like to see here.

Key Improvement Measures

Partnerships undertaking this project may select from among the following measures, with their associated metrics and data sources.

Reduced preventable inpatient admissions and readmissions. the number of individuals cycling through multiple systems, such as the criminal justice system, the general acute inpatient system, and the mental health system	Evaluate the total decrease in individuals who cycle through multiple systems based on pre- and post-project evaluation.	Project evaluation report
Promoting adherence to treatment goals and increasing medication compliance	Evaluate the total decrease of individuals who cycle through multiple systems due to poor medication persistence.	Project evaluation report

Comment [C7]: But how are you going to measure these admissions and readmissions? Contact with the CJ system, etc.? Again, I think the evaluation should be a project component, but you need to identify the outcomes you want to achieve here.

Comment [MD8]: Based on pre and post project evaluation?

Project I.1.C: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care

Project Goal

Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or needed care in a timely manner either because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts (or school scheduling conflicts in the case of children) or because they have obligations to provide care for children or elderly relatives during normal work hours. While such barriers to access can compromise anyone’s ability to make or keep scheduled appointments, individuals with behavioral health needs may be especially negatively affected. Many individual with behavioral health needs are reticent to seek treatment in the first place and such barriers may be sufficient to prevent access entirely. Others may be easily discouraged by such barriers and may drop out of treatment. Any such delay in accessing services or any break or disruption in services may result in functional loss and the worsening of symptoms. These negative health outcomes come at great personal cost to the individual and also result in increased costs to payers when care is finally obtained.

In order to mitigate the effects of these barriers to accessing care, Texas proposes to take specific steps to broaden access to care that will include an expansion of operating hours in a select number of clinics, an expansion of community-based service options (including the development of mobile clinics), and an expanded transportation program that will support appointments that are scheduled outside of normal business hours.

Potential Project Elements

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

Potential Project Elements
2. Expand the number of community based settings where behavioral health services may be delivered in underserved areas
3. Develop and staff a number of mobile clinics that can provide access to care in very remote or impoverished areas of Texas.
4. Expand existing transportation programs and ensure that transportation to and from medical appointments is made available outside of normal operating hours.

Key Process Milestones
Regional Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
1. Identify areas which lack sufficient transportation to appointments and extended operating hours	Assessment of gaps in accessibility to establish / prioritize geographic areas for intervention	<ul style="list-style-type: none"> Survey of inpatient and outpatient providers, interviews with key stakeholders Clinic records regarding kept and missed appointments
2. Establish extended hours, transportation and / or mobile options	<ul style="list-style-type: none"> * Number of areas prioritized for intervention with options in operation * Number of patients served in these options 	<ul style="list-style-type: none"> Project data

Comment [MD9]: Need to address project element #2 somewhere in measures.

Comment [C10]: I also think you need to expand out this section to include some of the basic steps along the way to implementing, say, a mobile clinic. Examples: hire and train staff to operate/manage the mobile clinic, identify requirements and licenses to operate a mobile clinic, etc.

Key Improvement Milestones
Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

1. Increased utilization of community behavioral health, reduced inappropriate use of institutional care, ER.	<ul style="list-style-type: none"> Service utilization before and after access expansion. 	<ul style="list-style-type: none"> Claims data and encounter data from inpatient, ED, community behavioral health sites Claims and encounter data from expanded transportation programs.
2. Improved adherence to scheduled appointments.	<ul style="list-style-type: none"> Compare the number of canceled or “no-show” appointments prior to access expansion with the number of missed appointments following access expansion. 	<ul style="list-style-type: none"> Clinical records from community-based settings
3. Improved consumer satisfaction	<ul style="list-style-type: none"> Survey data from CAHPS, MSHIP or other validated 	<ul style="list-style-type: none"> Data from completed consumer satisfaction

Key Improvement Milestones

Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

	instrument.	surveys.
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Project I.1.E and F: Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas (i.e., psychiatrists, psychologists, LMSWs, LPCs and LMFTs.

Project Goal

The goal of this project is to enhance access and reduce shortages in specialty behavioral health care to improve local integration of behavioral health care into the overall health delivery system; improve consumer choice and increase availability of effective, lower-cost alternatives to inpatient care, prevent inpatient admissions when possible and promote recovery from behavioral health disorders. The supply of behavioral health care providers is inadequate in most of the State. In 2011, 195 (77%) of Texas' 254 counties held federal designations as whole county Health Provider Shortage Areas (HPSAs) in relation to behavioral health.⁴

Potential Project Elements

- A. Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps.
- B. Develop plan to remediate gaps identified and data reporting mechanism to assess progress toward goal.
- C. Implement strategies defined in the plan to encourage behavioral health practitioners serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county. Examples of strategies could include marketing campaigns to attract providers, enhanced residency programs or structured financial and non-financial incentive programs to attract and retain providers.
- D. Assess and refine strategies implemented using quantitative and qualitative data.

Key Process Milestones

Regional Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
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⁴ "Highlights: The Supply of Mental Health Professionals in Texas -2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at: <http://www.dshs.state.tx.us/chs/hprc/publicat.shtm>

Key Process Milestones

Regional Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
4. Conduct gap analysis	<ul style="list-style-type: none"> Baseline analysis of behavioral health patient population, which may include elements such as consumer demographics, proximity to sources of specialty care, utilization of emergency room , other crisis and inpatient services including state hospital services used by residents of the region, incarceration rates, most common sites of mental health care, most prevalent diagnoses, co-morbidities; existing provider caseload, provider demographics and other factors of regional significance 	<ul style="list-style-type: none"> HPSA data Provider licensing and enrollment data from state and local sources Claims and encounters from regional and state data sources Provider and consumer survey, interview and focus group data
5. Develop remediation plan	<ul style="list-style-type: none"> Plan addressing elements required in gap analysis 	<ul style="list-style-type: none"> Written plan from Regional Partnership
6. Asses and refine strategies	<ul style="list-style-type: none"> Project planning and implementation documentation reflects plan, do, study act quality improvement cycle 	<ul style="list-style-type: none"> Project reports

Comment [C11]: Agree with comment below – might also want to be explicit about considering peer counselors, BH-trained community health workers, etc.

Comment [MD12]: Suggest discouraging just hiring more doctors by adding additional text to this metric to imply that (like the title of this menu item) the solution must be broader. For example, training in psychopharmacology of psychologists in rural areas and from special populations can help overcome shortages of mental health specialty services in rural areas and for special populations vs. just hiring more psychiatrists. Training other healthcare professionals in BH issues can reduce the burden on BH specialists.

Key Improvement Milestones

Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

1. Increase incidence of positive outcomes	<ul style="list-style-type: none"> Increased number of behavioral health providers serving medically indigent public health clients Decreased use of emergency room by indigent BH consumers Decreased medically 	<ul style="list-style-type: none"> HPSA data Provider licensing and enrollment data from state and local sources Claims and encounters from regional and state data sources Provider and consumer
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Comment [C13]: This is not an outcome – you could break this out into its own metric.

Key Improvement Milestones

Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

	indigent potentially preventable inpatient admissions related to behavioral health causes <ul style="list-style-type: none"> • Increased consumer satisfaction • Decreased use of state psychiatric facility beds • Increased provider and stakeholder (county judiciary, county commissioner) satisfaction 	survey, interview and focus group data
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Key Improvement Milestones

Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric	Data Source
Increase number of individuals residing in underserved areas that have benefited from enhanced access provided through telemedicine, telehealth and telemonitoring services.	Number of individuals residing in underserved areas that have benefited from enhanced access provided through telemedicine, telehealth and telemonitoring services.	Demographic and encounter information from eligibility and claims data.

Comment [C14]: Would also suggest a measure of patient satisfaction or patient experience with the use of telehealth.

Comment [C15]: Please be clearer about what you mean by "have benefited from." Do you mean the number of patients who have used telemedicine services to have a consult or appointment? Or do you mean something else related to improvement in their care or outcomes?

Comment [C16]: I presume there are codes on claims for telemedicine consults?

Project II.5.E.: Recruit, train and support consumers of mental health services to be providers of behavioral health services.

Project Goal

Project Goal

The goal of this project is to use 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. These services are supportive and not necessarily clinical in nature. Building on a project originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as whole health peer support specialists. With this training they are working with other consumers to set achievable goals to prevent chronic diseases such as diabetes and COPD, or to address them when they exist. While such training currently exists, very limited numbers of peers are trained due to resource limitations. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness⁵. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population⁶), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase⁷.

Comment [MD17]: Not sure if it is helpful, but you may want to review the following paper related to this initiative:
<http://www.transformation-center.org/advocacy/policy/transcom/pdf/Peer%20specialist%20position%20paper%2006.pdf>.

Potential Project Elements

1. Identify peer specialists interested in this type of work and train them in whole health interventions.
2. Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.
3. Identify patients with serious mental illness who have health risk factors that can be modified.
4. Implement whole health peer support.
5. Connect patients to primary care and preventive services.
6. Track patient outcomes.

Comment [C18]: I think these overall require more specificity

Key Process Milestones

Regional Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
7. Identify and train peer specialists to conduct whole health classes.	<ul style="list-style-type: none"> • Number of peers trained in whole health planning. 	<ul style="list-style-type: none"> • Training records
8. Select and implement a health risk assessment (HRA) tool.	<ul style="list-style-type: none"> • Number of HRAs completed by consumers. 	<ul style="list-style-type: none"> • Internal data base

Comment [MD19]: Also suggest training primary care providers so that they understand the role of the peer specialists and this may encourage peer specialists and traditional providers to work together successfully. One challenge that has been cited with this type of program is the lack of clarity on the role and responsibilities of a peer specialist in relation to traditional providers and therefore the lack of acceptance by traditional providers. Training primary care providers and not just the peers may improve this situation.

⁵ Benjamin G. Druss, MD, MPH, Liping Zhao, MSPH, Silke A. von Esenwein, PhD, Joseph R. Bona, MD, MBA, Larry Fricks, Sherry Jenkins-Tucker, Evelina Sterling, MPH, CHES, Ralph DiClemente, PhD, and Kate Lorig, RN, DrPH, The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness, *Schizophrenia Research*, Volume 118, Issue 1, Pages 264-270, May 2010

⁶ Parks, J, Svendsen, D, et. al. "Morbidity and Mortality in People with Serious Mental Illness", National Association of State Mental Health Program Directors, 2006.

⁷ Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." *Robert Wood Johnson Foundation, The Synthesis Project: Issue 21* (2011).

Key Process Milestones
Regional Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
9. Identify health risks of consumers with serious mental illness.	<ul style="list-style-type: none"> Number of consumers identified with modifiable health risks. 	<ul style="list-style-type: none"> Internal data base
10. Implement Whole Health classes.	<ul style="list-style-type: none"> Number of participants entering and completing classes. 	<ul style="list-style-type: none"> Internal records

Comment [C20]: Need some specificity on what this is – seems very broad.

Key Improvement Milestones
Partnerships undertaking this project may select from among the following Milestones, with their associated metrics and data sources.

Milestone	Metric(s)	Data Source(s)
1. Consumers receive appropriate primary care and preventive services.	<ul style="list-style-type: none"> Number of consumers receiving primary care and preventive services. 	<ul style="list-style-type: none"> Encounter data
2. Track outcomes for consumers who participate in whole health peer support.	<ul style="list-style-type: none"> Reductions in targeted symptoms increased preventive behaviors (e.g., physical activity) Increased health related quality of life 	<ul style="list-style-type: none"> Internal registry or other tracking mechanism

Comment [C21]: Overall you need to define exactly what outcomes you want to achieve and articulate them separately as metrics. These are too general.